

Annual report and accounts 2021-22



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Foreword from the Clinical Chair

Two years ago, as I was writing this foreword to the 2019-20 annual report, it was becoming clear that the world was to be affected by a devastating new virus. Today, while it is still much too early to say that COVID-19 is behind us, many of us are for now returning to living more or less normal lives. For this, we have the vaccine to thank.

There is, however, no cause for easing our vigilance.

The NHS in Devon, as across the country, has been stretched to the limits by COVID-19 but has met the challenges through a heroic response from those who work for it.

I need here to make special mention of our GPs in Devon, who in short order this year organised and delivered a comprehensive vaccination programme, so that by now our adult population has found it straightforward to get further protection from a third – or booster – dose.

Vaccination was extended to young people in the 11-17 year-old group before Christmas.

The complexity and logistical challenges in devising and delivering this programme within tight timeframes are hard to overestimate, because it has been in addition to the GPs' already great workload in looking after their patients. Nonetheless, our GPs have ensured they can continue to meet people's urgent care needs, and – in difficult circumstances - still managed this year to offer greater than ever numbers of appointments, either in person, online or by telephone.

This result is due in no small part to strong leadership, which has been provided by GPs in our collaborative boards, and in our primary care networks.

We are privileged in Devon to have such excellent general practice, with colleagues who continue to work tirelessly to deliver services. Our GPs and their teams are committed to delivering the best care possible for our population, more recently in the face of rising abuse and unacceptable behaviour by some members of the public, fortunately a minority. We understand of course that people are frustrated and often anxious about their own health, but we continue to be shocked by the instances of verbal abuse and aggression directed towards our primary care colleagues.

For this reason, it was all the more gratifying to see our GP practices once again score so highly in the annual patient survey. My thanks go to all of them.

COVID-19 has also seen a terrific but largely hidden response from our colleagues in pathology – those who analyse tests. For about 75 percent of people, contact with the NHS will involve this testing service. Last August saw Devon pathologists carry out their one-millionth COVID-test analysis. They have coped every day with vast numbers of NHS staff, patients, care home residents and staff, social care and mental health staff who have needed to be tested, mostly to keep others safe. To meet this demand, they successfully opened the new Lighthouse laboratory in Plymouth and reorganised their ways of working so that the “everyday” work of analysing a huge range of tests remained uninterrupted. So, hats off to pathology, as well.

The smooth running of care in a pandemic requires collaborative working by everyone in all parts of the care system, from GPs, our hospitals, social care, mental health, the voluntary sector and community groups.

As we move to becoming a formal Integrated Care System in Devon by July this year, this collaborative approach is paying dividends.

Among other things, it has allowed our district hospitals in Exeter, Plymouth, Barnstaple and Torquay to treat people in need of urgent care, even when they have been so busy. Coming together to form provider collaborative organisations, they have worked together to agree, for example, the best use of beds for people with COVID-19 and accepted that in some cases care needs to be provided in settings other than their own. Community services and social care have worked in similar fashion to provide best care, despite significant workforce shortages.

This is not to say that we are without challenges, and we recognise that we need to work as quickly as we can to attend to those who because of COVID-19 have faced delays in their care, be that surgery or outpatient appointments or management of long-term conditions.

The Nightingale hospital that was built in Exeter for COVID-19 patients will be put to use now to provide extra theatre space for operations and procedures. We continue to work with the independent sector. And we have designated some “protected” capacity at Plymouth so that planned operations do not need to get cancelled at short notice by a rush of emergencies.

This will have been the last full year of the Devon Clinical Commissioning Group, before it dissolves and becomes part of the Integrated Care System. I believe this new, collaborative system will be of great benefit to our population in Devon, as we work together more closely than ever before.

I would like to thank the CCG staff, who have made the organisation one to be proud of and who have been adjusting so adroitly to the new ways of working that lie ahead. We need now to capture all that we have learnt in the last few years about the best ways of providing high quality care for local people and ensure that this is passed on so that all those in Devon can be well supported to live the best, and healthiest, lives possible.



Dr Paul Johnson

Clinical chair, NHS Devon Clinical Commissioning Group

Performance report

Overview

This overview provides general information about NHS Devon Clinical Commissioning Group (CCG), its purpose, and performance during the year. The CCG was established on 1 April 2019, from a merger of two previous CCGs, Northern, Eastern and Western Devon CCG and South Devon and Torbay CCG. During the year ahead, it will cease to exist, becoming part of the wider Integrated Care System in Devon.

COVID-19 pandemic

Working side by side with its partners, the CCG has continued to coordinate the response to COVID-19 to ensure the best possible care for people across Devon.

This year the focus has very much been on offering our population the protection of vaccination, the most important means of minimising the severity of the virus for those who catch it. And, while our hospitals and GPs have remained extremely busy, we have indeed seen a reduction in the numbers of deaths and seriously ill patients in our intensive care units.

By the end of 2021 – one year after the very first, elderly patients in Devon got vaccinated - we were able to offer the vaccination to all those in the 11-17 year age group. This was carried out at short notice, in line with direction from the Government, and was achieved due to an effective response of our GPs and colleagues in primary care.

It built upon a consistent programme of vaccination offering first one, then a second vaccination to each age group, followed by a booster. By the end of the year, plans were in place to deliver a second booster in the spring of 2022 to those over 75, older people in care homes and those with weakened immune systems. These are the people in our midst who remain the most vulnerable. There will also be a programme to protect clinically vulnerable young children, using a lower dose of the vaccine. Children from 5 to 11 years old are eligible if they have diabetes, learning disabilities, conditions such as chronic heart or kidney disease, or if they live with someone whose immune system is suppressed.

In Plymouth, a collaborative vaccination outreach working group was established to improve vaccine uptake for populations affected by health inequalities and/or deprivation. Special focus was on asylum seekers, refugees and migrants, gypsies and Roma people, faith groups, homeless and vulnerable people, carers, students and young people of working age. This outreach model delivered regular vaccination walk-in sessions across the city, close to people's own communities, offering a dose to people aged 12+. An extra 19,350 vaccinations were carried out in this way between July and February, and the model has been adopted by other CCG localities.

The CCG's incident management team, established in March 2020, has continued to play an important role in passing on vital information to other parts of the NHS, including Devon's hospitals. These have their own strategic, tactical and operational structures in place.

The CCG, providers and primary care have continued to work with Public Health England to support care homes to keep their residents safe. This has, at times, meant the homes closing their doors to visitors, but in the later part of the year we worked to implement the system

under which residents could nonetheless be visited in their room by one named care-giver, in most cases a family member. This recognises the importance to people's wider wellbeing of maintaining contact with friends and family.

Once again, digital technology has played a crucial role in the COVID-19 response, particularly in ensuring that GPs can continue consultations with patients in a safe, effective manner. More information on this can be seen in the digital section at page 22.

In research, 545 Exeter people were among a total of 15,000 across the UK to be recruited in only five and a half weeks in 2020 to take part in the phase 3 trial for Nuvaxovid™, the Novavax COVID-19 vaccine.

The trial was supported by more than 100 healthcare staff from across the Royal Devon and Exeter NHS Foundation Trust, local GPs, the Patient Recruitment Centre in Exeter, the National Institute for Health Research clinical research facility Exeter, and staff from other organisations.

Two years on and Nuvaxovid™ has been approved as the first protein-based vaccine option to be administered for 1st and 2nd doses. Due to its different nature, it will be much easier to store and transport to other countries across the world.

Dr Ray Sheridan, consultant physician at the RD&E and principal investigator, said: "Millions of doses will be used to supply countries worldwide. We are all safer when we are all vaccinated."

Highlights of the year

These are some of the positive developments we have seen in the past year.

Vote of confidence in GPs

Devon GPs once again scored highly in the annual patient survey, with almost nine out of 10 people saying their local family doctor service was good.

Devon's doctors and their practice colleagues were rated above the national average in several categories.

- Overall, 88% of people in Devon described their experience of their GP practice as good. This is up by 2% on last year and above the national average of 84%
- Nearly three quarters (74%) said it was easy to get through to someone at the practice on the phone. This is also up on last year's figure and above the national average of 68%
- 92% said receptionists were helpful. National average is 89%
- 87% satisfied with the appointment offered. National average is 82%
- 69% saw someone for a face-to-face appointment
- 87% of people were satisfied with the appointment they were offered. The national average was 82%.

This was despite the extra pressure on primary care due to the COVID-19 pandemic and the need to deliver the continuing vaccination programme.

New provider for NHS 111 and out of hours GP services

After a comprehensive procurement process, a new organisation was appointed in February 2021 to run urgent care services in Devon, ensuring that people get straightforward access, round the clock, to high quality care.

From October 2022, NHS 111 and out of hours GP services will be run by Practice Plus Group Urgent Care (formerly known as Care UK). The group currently answers 1.5million calls a year to NHS 111, and runs out of hours services, urgent treatment centres, minor injuries units, hospitals and general practices nationwide.

In Devon, it will also run the clinical assessment service, in which clinicians use their expertise to respond to callers, prioritising cases and directing people to the most appropriate services.

The contract is for three years from 1 October 2022, with room for a two-year extension.

Out-of-hours and NHS 111 services have been under pressure for the last few years, both in Devon and nationwide, particularly since the COVID-19 pandemic.

The specification for the contract was built on what patients using the service told the CCG they needed and what they wanted to change. Questions to bidders were therefore based on the insight provided by those using the NHS 111 and GP out-of-hours services. Patient representatives were involved in the final evaluation of the bids.

Since 2016, the service has been run by Devon Doctors Ltd. Amid the mounting pressures and staffing problems seen nationwide, Devon Doctors at times experienced difficulties meeting demand.

Dr Paul Johnson, clinical chair of Devon CCG, said he was confident that people in Devon would see real improvements in the 111 and GP out-of-hours services.

He also thanked Devon Doctors for its dedication and hard work over the past years in providing the service in what he recognised had been testing circumstances, particularly with the COVID-19 pandemic.

One Northern Devon

One Northern Devon sees the NHS work in equal partnership with its local communities to make a difference to people's lives. The Flow Programme is its flagship approach to delivering person-centred care that aims to transform the way services support people with multiple or complex needs. The High Flow programme focuses on people with the most complex needs who are high users of emergency services, often with a history of childhood trauma. In one year, the programme's holistic support to individuals reduced demand on services, particularly A&E, by £103,831 against a cost of £48,000. Its success was noted by the Chief Executive of the NHS Confederation, who highlighted High Flow in his opening address to the organisation's 2021 conference. Other Flow programmes include Primary Care Flow which was used as a way of managing population health through Barnstaple Alliance Primary Care Network (PCN). It is now being piloted across the whole Northern Devon locality with buy-in from all four PCNs.

The seven One Communities that make up the One Northern Devon ‘family’ have been busy engaging with their communities on mental health needs, food provision and loneliness. One Community Developers have been improving provision and working with community groups to address the needs highlighted through their engagement and surveys. More recently they have been providing a ‘Community around the Person’ service to support people from their community who are taking part in the Flow projects.

One Northern Devon was referenced in this national ‘State of the Nation 2021’ report from the Institute of Health Equity [‘Addressing the National Syndemic: Place-based solutions to UK health inequality’](#) and is now in the process of updating its [current health inequalities strategy](#). Its health inequalities team has been gathering latest public health data, engaging with partners and embarking on an engagement exercise with people experiencing inequalities.

One Northern Devon’s latest report covering all of its current work can be found [here](#)

Pathology in Devon

Pathologists in Devon carried out their one millionth COVID-19 test analysis in August 2021 as they continued to adapt ways of working to meet the extra pressures presented by the virus. The teams excelled in meeting the demand for swift COVID test results, at the same time as maintaining their routine testing work on behalf of hospitals and the health system.

To boost capacity, the Lighthouse laboratory in Plymouth was established in a short timeframe, dealing with some 40,000 samples a day for local testing stations and care homes. The centre was consistently one of the top performers in the country.

A procurement exercise identified a preferred supplier for a new digital histopathology service that will start in summer 2022. This will make it easier to process more images, with improved turnaround times for biopsies and the ability to share results swiftly with those healthcare staff concerned with the next steps in the patient’s care and treatment.

The Peninsula Pathology NHS Network was strengthened in terms of governance during the year, with more executive representation on its Board and a clinical effectiveness group making decisions, for example about new tests, that are passed to a new operational delivery group for implementation.

The network has also benefitted from national NHS England/Improvement funding for some dedicated posts in the diagnostics workforce, taking in both imaging and pathology.

Work started on Health and Wellbeing Centre for Dartmouth

With all planning conditions met, work on a new Health and Wellbeing Centre for the people of Dartmouth got under way in June 2021. The purpose-designed centre will open at the top of the town during 2022.

It will give people from Dartmouth and surrounding villages access to a broad range of health, care and wellbeing services in one place, bringing together GPs, community nurses, therapists, Dartmouth Caring and a pharmacy all under one roof.

Backing the development, local councillor, Ged Yardy, said: “Having a single centre where local people can attend their clinic appointment, see a GP, find about local services, and pick up their prescription – whether that’s social prescribing or medication – will make a real

difference. It will also be good to see our GPs, nurses and therapists working together from modern, fit-for-purpose facilities.”

New purpose-built GP practice invests in patients’ future

A brand new, purpose-built GP practice opened for the people of Crediton in October 2021 thanks to collaborative working between local GPs and the wider NHS. It enables the clinical teams from Redlands Primary Care to provide patients with the care they need more efficiently and easily from a modern, purpose-built facility.

The new building will future-proof the delivery of healthcare locally for Crediton and the surrounding communities for decades to come.

The project, costing £8 million, is one of a number of sites across the country to receive major NHS funding to improve facilities. Eighty percent of the funding has come from a long term loan from the NHS England Estates and Technology Transformation Fund (ETTF) – a national funding programme to support GP practices to make improvements to services for local patients including more modern, expanded facilities, use of new technologies. Additional funding has been loaned by Mid-Devon District Council.

The population of Crediton is expected to rise significantly over the next five years. The new facility will provide patients with a state-of-the-art health hub that can tackle the current and future challenges for health and care for a much larger population than it currently serves.

Services will be provided from the new GP practice that are much broader than those traditionally offered by GP practices. There will be a greater focus on prevention and wellbeing services, with more community and specialist clinics located on site, working much more closely with the general practice team.

The new site offers expanded general practice teams, including advanced nurse practitioners and paramedics, improving access to clinicians at the practice.

Health and Wellbeing Centre for Plymouth

Plans are being developed for a Health and Wellbeing Centre in Plymouth’s West End, with a broad range of organisations and stakeholders within the city working together on the project.

The new building would not only provide a much-needed modern health and community facility, but would help kick start the regeneration of the Stonehouse area..

Diabetes support close to home and in hospital

More than 75,000 people in Devon live with type 2 diabetes. The 2020/21 Diabetes Transformation Fund enabled the CCG localities to create a number of pilots this year, designed to help people get the support they need in their own community, or the best treatment, diagnosis or management in hospital.

The Torridge Primary Care Network appointed a diabetes support nurse for 12 months to improve patient care closer to home, to help people with their treatment, reduce the numbers referred to specialist care and improve people’s experience. This will be spread to other primary care networks if a review shows positive results.

At the Royal Devon and Exeter Hospital and North Devon District Hospital, a specialist diabetes pharmacist was appointed for 12 months to review diabetic patients and their

medications and update care plans. The pharmacist takes part in diabetes ward rounds and works with pharmacists in primary care networks to improve the way people are referred for care.

Dementia care in Western Devon

The Western Locality commissioned 16 beds for people with dementia or cognitive impairment at Woolwell Dementia Care Home give additional capacity to the healthcare system and help reduce the length of hospital stays for these patients.

Woolwell has been commissioned to offer a short stay facility of no more than four weeks, with the right support so that better long-term decisions can be made, to help ensure that people do not enter long term care too early and wherever possible go to their own home with support. The service includes multidisciplinary team calls with older people's mental health.

New treatment for prostate cancer patients

Torbay and South Devon NHS Foundation Trust's radiotherapy department started treating prostate cancer patients with a new technique that could greatly reduce the doses of radiation received and cut the number of hospital treatments needed.

They are using the pioneering technique of stereotactic ablative radiotherapy (SABR) as part of a trial under PACE, led by the Royal Marsden NHS Foundation Trust.

SABR uses advanced imaging technologies with sophisticated computer planning to safely deliver precisely targeted radiotherapy using fewer high doses of radiation. This means patients attend hospital for as few as five visits as opposed to many more over several weeks.

Investments

Hospital improvements

Work on a £20million state-of-the-art Emergency Department at the **Royal Devon and Exeter (RD&E) Hospital** has been progressing, with funding from the New Hospital Programme.

The project enables the hospital to expand its clinical services with a first rate treatment environment. As the RD&E is a teaching hospital, it will also provide high-quality education and training space for future generations of medical students.

Inside will be eight new resuscitation bays consisting of six adult bays and two dedicated paediatric bays. There will also be a specialist children's department with a paediatric assessment unit providing a child-friendly environment. A new area has also been created to see and treat those with minor injury and illness, and a new reception area will house a larger waiting room, with natural light.

Under the same initiative, **University Hospitals Plymouth** is progressing with work on a new emergency care facility, bringing together urgent and emergency care and providing dedicated areas for children, frail people, and those needing same day emergency care. The first phase sees the existing Emergency Department replaced by 2024.

Torbay and South Devon Hospital Trust is using this funding to build a £15million Acute Medicine Unit, due to open in the autumn of 2022. This will double the number of assessment spaces to 52, ensuring patients get timely access to the right care.

Northern Devon Healthcare Trust also continued work on improvements to its hospital facilities, replacing ageing estate and allowing the delivery of new models of care.

Funding for planned care

Health and care partners in Devon received £11.3million from the national Accelerator Systems Programme (ASP) to spend on three initiatives to reduce waiting times for routine – or planned - operations in Devon, Somerset, Cornwall and Dorset.

Learning from what works well in Devon and other sites nationwide will then help form a blueprint for the recovery of planned care across the country, after the delays caused by the COVID-19 pandemic.

The three initiatives were identified as:

- Increasing the number of planned orthopaedic operations at the Nightingale Hospital in Exeter, with ready-made operating theatres and diagnostic services such as CT and MRI scans
- Increasing the number of eye operations in Plymouth, with a purpose-built modular ophthalmology unit at Derriford Hospital for eye operations such as cataract removal
- Introducing eye operations in community settings

Awards

Health Service Journal awards

Pathologists from the Royal Devon and Exeter Hospital took the prize for innovation in the acute sector at the 2021 Health Service Journal (HSJ) awards, for their patient-led home testing initiative. The new service allows people to take a blood sample at home with a single finger prick. Within a few days they can view safe and precise results – kept confidential and anonymised to others - on an easy-to-read online dashboard.

Torbay and South Devon Foundation Trust, partnered with Health Care Innovations, was a finalist in the driving efficiency through technology category, for its CONNECT Plus scheme. This is an app for multiple conditions, that has reduced demand for healthcare by supporting patients to manage their conditions themselves.

The southwest also featured in the HSJ provider collaboration of the year category for work in maternity. The southwest neonatal operational delivery network, together with the West of England and Southwest England academic health science networks, was shortlisted for their work in reducing pre-term brain injury.

At the 2021 HSJ Patient Safety awards, Devon Partnership NHS Trust, which provides mental health services, took away the trophy for its work with the RD&E in connecting mental health and physical health services for gastroenterology patients. They won the mental health initiative of the year with the 'Gastroenterology Big Room' project, which the judges

said had enabled an impressive cultural shift, with patients speaking passionately about the difference the service had made.

In separate HSJ awards, the RD&E Hospital won the specialist service redesign initiative award for its work to support patients living with cancer.

In collaboration with Clatterbridge Cancer Centre NHS Foundation Trust, the team developed Enhanced Supportive Care (ESC), which promotes earlier implementation of supportive or palliative care for patients with cancer to prevent and manage adverse effects of cancer and cancer treatment.

The team found that those who access ESC have a better experience, a considerably reduced burden of symptoms, a greater chance of completing chemotherapy, less likelihood of an unplanned admission and less time spent in avoidable visits to hospital.

ICE award for Nightingale Hospital

The extraordinary effort to build Nightingale Hospital, Exeter in just 57 days was recognised at the Institution for Civil Engineers southwest awards, which showcase achievements in engineering. Thousands of people played a part in constructing the facility, designed to provide extra capacity during the COVID-19 pandemic, turning a retail unit into a state of the art facility for patients.

The Nightingale project team won the “Collaboration of the Year” category for the hospital, which cared for almost 250 patients at the height of the pandemic and has since provided important diagnostic scans for local people.

Positive practice

Devon Partnership NHS Trust won six awards and three highly commended mentions at the national Positive Practice in Mental Health Awards in London. The winners were:

- Mental Health/Learning Disability Nurse of the year - Emma Gillard
- Improving Access to Psychological Therapies - TALKWORKS
- Complex needs - Iris Centre
- Primary and community mental health - Exmouth community mental health team
- Specialist services - Bristol Dementia Wellbeing Service
- Community forensic – Innovation in community mental health

Highly commended

- COVID-19 team of the year - Community Forensic Service
- Forensic secure services – Exeter prison mental health team
- Integration of physical and mental health care - Physical therapies team

Win for ConnectPlus App

An app which helps people manage their health conditions and was jointly developed by Torbay and South Devon NHS Foundation Trust and local company Health and Care Innovations won a national Building Better Healthcare Award for best patient-centred healthcare software.

The app, CONNECTPlus, helps people to manage multiple health conditions from their own phone or device, providing 24/7 access to a range of features including symptom trackers, medication management and appointment reminders, as well as accredited information and content provided by their own doctors and other healthcare professionals.

Currently CONNECTPlus is being used by a number of specialities in Torbay Hospital, including rheumatology, neurology, diabetes, gastroenterology and orthopaedics. It will be used in other departments, such as cardiology and respiratory, in the next few months.

Queen's Nurses

At Devon Partnership NHS Trust, Laura Ireland and Jo Broderick, community children's nurses with Children and Family Health Devon were awarded the prestigious title of Queen's Nurse. Laura and Jo received the honoured title from the Queen's Nursing Institute, recognising their high standards of community mental health nursing practice.

Care home worker scoops award

Dave Gearing, a maintenance worker at The Firs residential care home in Budleigh Salterton, won a local award for going above and beyond for residents. After only 15 months at the home, he won the award from Devon County Council, the RD&E, and GPs from the Woodbury, Exmouth and Budleigh Primary Care Network, who praised his passion for making a difference to individuals.

NHS Devon CCG performance rating

In light of the ongoing pressures of COVID-19 and updated priorities, NHS England took a simplified approach to this year's CCG assessment programme. Dispensing with the usual CQC-style four label categorisation, it provided a narrative assessment, which takes account of individual circumstances within each ICS.

This year the annual assessment focused on CCGs' contributions to local delivery of the overall system plan for recovery, with emphasis on the effectiveness of working relationships in the local system. The assessment took the form of self-assessment and a follow up meeting between NHS England/Improvement.

In summary, NHS England noted that the CCG has/is:

- demonstrated its leadership role in managing the wider system response to COVID-19, as well as the work with partners to maintain, and more recently restore services and activity to pre-COVID-19 levels
- Fully engaged with Integrated Care System and Integrated Care Partnership developments, as well as Primary Care Networks.

- Been finalists or winners in a number of awards, notably the HSJ Partnership Awards 2020 (with partners) and HSJ awards (2020) for the Devon Carers' hospital, One Northern Devon and Devon Digital Accelerator.
- Maintained robust engagement with patients, particularly development of the CCG's Ethical Framework for Devon and use of the Devon Virtual Voices Panel to engage with ethnic minority community members, people with autism and people with learning difficulties, as well as over-65s.
- Ended the year in a breakeven financial position – as have all CCGs across the southwest.

The letter recognised that the CCG leadership team and the entire CCG workforce have worked extremely hard, at pace, and under challenging conditions.

Our purpose and activities

NHS Devon CCG is the local headquarters for the NHS in Devon.

As of July 2022, the CCG will be merged into the Integrated Care System for Devon and will cease to exist as a statutory body.

We have been responsible for commissioning, or planning and buying, most healthcare services for the 1.2 million people who make up our local population. Our aim is to improve people's lives, to reduce inequalities in health, and make sure that with our partners in the Integrated Care System we can deliver our services for the long term.

We work with our local communities and partner organisations to improve people's health and wellbeing and make sure they have safe, high quality, local services. We are responsible for commissioning £1.9billion of healthcare services. This does not include dentists, pharmacies or all specialised NHS services, but we have full responsibility for commissioning GP medical services, under authority delegated by NHS England.

The CCG is a membership body made up of all the GP practices in Devon. We are a clinically-led organisation. Our chair is a local GP, and we employ other Devon GPs to provide clinical leadership for key areas or to serve on the CCG's Governing Body. Full details of our Governing Body are on page 81.

Our vision, mission and strategic objectives

Our vision and values were drawn up with our staff on the creation of a single CCG for Devon in consultation with our staff.

Our vision: Working together for Devon

Our mission: Working together to commission the right services that improve lives of those who live in Devon

Our strategic objectives:

The CCG's strategic objectives were updated in early 2021, with staff helping develop them.



The CCG takes joint ownership with our partners and the public for creating sustainable health and care services. Our commitment to this is evidenced by our active role in developing the Integrated Care System for Devon (ICSD), and by our extensive discussions with, and involvement of, people using services.

The CCG executive members take corporate and personal accountability for driving and enabling achievement of these objectives through their leadership roles.

Moving towards the Integrated Care System for Devon (ICSD)

The ICSD is working within agreed formal structures and governance.

It will set strategic objectives and outcomes to improve the health and well-being of the Devon population (Population Health Management) and implement the Long-Term Plan for Devon.

Its work will include:

- Determining the allocation of resources to “places” (sub sections of the county based on a geographical footprint and recognised in county boundaries) that are served by Local Care Partnerships
- Ensuring that health inequalities are addressed across Devon
- Collaborating with partners outside health and social care that have a direct impact of the health and well-being of the population, eg housing, employment, education etc
- Supporting the spread and adoption of best practice
- Instigation and oversight of large-scale strategic transformation projects
- Accountability back to the population of Devon
- Assurance of delivery of the expected improvements in outcomes within the resource envelope and to agreed performance, quality and regulatory standards

- Ensuring active and effective stakeholder engagement and public participation at system level

Commissioning local services

We assess the needs and strengths of the local population and communities before designing and buying services to match those needs. We have a statutory duty to do this in an open, transparent and careful manner, ensuring patients and their families have the highest-quality experience of their health care.

To make sure our plans for local services are comprehensive and representative, we talk to clinicians and health professionals, and we canvas patients' views, working with Healthwatch in Plymouth, Torbay and Devon. Details of how we engage with our communities and how they are involved in our commissioning decisions are set out on [page 41](#).

The CCG has a statutory responsibility to act transparently, proportionately and without discrimination, recognising the responsibilities to consult and engage. The work the CCG does is underpinned by the principles and values set out in the NHS Constitution.

Our operational structure and the business environment

The commissioning architecture introduced under the Health and Social Care Act 2012 was designed to place the responsibility for decision-making with clinicians to ensure the focus always remains on the individual patient.

Our CCG has commissioned most healthcare services, including:

- Primary care
- Planned hospital care
- Rehabilitation care
- Urgent and emergency care (including out-of-hours care and ambulance services)
- Most community health services
- Maternity and new-born services
- Mental health and learning disability services
- Children's and young people's health services
- Continuing healthcare for people with ongoing health needs

CCGs can commission any service provider that meets NHS standards. These can be NHS organisations, social enterprises, charities or private sector providers. However, they must be assured of the quality of services they commission, considering National Institute for Health and Care Excellence (NICE) guidelines and the Care Quality Commission's (CQC) data about service providers.

The CCG has a statutory responsibility under the NHS Procurement, Patient Choice and Competition Regulations 2013 and the Public Contract Regulations 2015. This must be

discharged in procuring healthcare services for the NHS, to secure services that meet patients' healthcare needs and improve quality and efficiency.

Details of how the CCG meets its legal obligations in relation to procurement and in accordance with the Constitution can be found within the CCG's procurement policy. Where appropriate, the procurement of services is considered in conjunction with other NHS commissioning organisations. Opportunities for providing healthcare services are advertised on the Government Contracts Finder website.

CCGs are overseen by NHS England, which ensures that CCGs have the capacity and capability to commission services successfully and to meet their financial responsibilities. NHS England has a duty under the Act to promote the autonomy of local clinical commissioners.

NHS England and CCGs have a duty to involve their patients, carers and the public in decisions about the services they commission.

In 2021-22 the CCG commissioned its main services from the following key providers:

- Devon Doctors Ltd
- Devon Partnership NHS Trust
- Livewell Southwest Community Interest Company
- Northern Devon Healthcare NHS Trust
- Royal Devon and Exeter NHS Foundation Trust
- South Western Ambulance Service NHS Foundation Trust
- Torbay and Southern Devon Health and Care NHS Trust
- University Hospitals Plymouth NHS Trust

The CCG was established with four localities, each with its own clinical representative on the Governing Body: Northern Locality, which includes North Devon District Hospital, Eastern Locality, which includes the Royal Devon and Exeter Hospital, Southern Locality which includes Torbay Hospital, and Western locality, which included Derriford Hospital. In the last year, Plymouth has been working within its own locality structure.

Our area spans three local authority areas – Devon County Council, Torbay Council and Plymouth City Council, each with approved Better Care Funds which pool health and social care budgets, and each with a Health and Wellbeing Board.

People in Devon generally live longer than those elsewhere in the country, but there are still variations in life expectancy within the county. In certain parts of Devon we have the fastest growing ageing population and significant levels of deprivation exist within our urban areas with pockets of deprivation both in the towns and deeply rural areas of Devon. We are committed to working with our partner organisations to reduce these inequalities.

We operate in a business environment that involves managing risks – for further details, turn to the 'Risk management arrangements and effectiveness' section on page 94.

Review of the year

Integrated Care System

The CCG has worked with local authorities, social care, primary care, provider organisations, public health teams and a wide range of organisations – both statutory and community or voluntary – to improve people's lives.

The CCG has continued to play a leading role as the county moves to become an Integrated Care System (ICS) for Devon.

The formal transition to the ICS is expected in July 2022, with all organisations in Devon working in shadow ICS form until then.

In April 2021, Jane Milligan took up the role of chief executive of the Integrated Care System and the role of Accountable Officer of the CCG.

Through the ICSD, the CCG aims to effect the changes to health and care set out in the NHS Long Term Plan. This is intended to meet the growing challenges of providing community and hospital care and social care when demand is dramatically increasing. Through a Devon Long Term Plan, the national plan has been tailored to meet the needs of the population of Devon.

Partnership working, including with the independent sector and our four acute hospitals, has also been developed in the last year to ensure that those whose health needs have not been promptly addressed during the COVID-19 pandemic can receive the treatment they require.

The vision is: "Equal chances for everyone in Devon to lead long, happy and healthy lives".

The work programme for the ICSD will follow Devon's Long Term Plan.

Amongst many initiatives to improve the lives in collaboration with partners for the population of Devon the CCG has worked on:

Improvements for BAME communities

In June 2021, NHS and care leaders in Devon backed a series of recommendations to improve the experiences of people from ethnic minority communities in accessing and working in local health and care services.

It followed the publication of a report commissioned by the Integrated Care System for Devon (ICSD) on the 'Experiences of health and care in Devon for Black, Asian and Minority Ethnic communities and staff'. The report was researched and produced by independent specialists the Nous Group between September 2020 and February 2021.

The ICSD commissioned the report following local engagement work in summer 2020 on the development of an ethical framework for Devon in the face of the COVID-19 pandemic, during which negative experiences were shared by people from ethnic minority communities about access to healthcare, and a spotlight was put on the health inequalities faced by people from ethnic minority communities.

The report includes first-hand feedback from staff and patients. It demonstrates that change is needed, highlights some of the ways in which this is already happening, and sets out the areas for improvement.

A total of 29 recommendations were made by the Nous Group and all of them have been approved by the ICSD Board and the Governing Body of NHS Devon Clinical Commissioning Group.

The recommendations focus on key areas including:

- Building stronger relationships with ethnic minority communities to make sure health services meet people's needs
- Developing Black, Asian and Minority Ethnic reference groups (staff and public) which will provide a platform for feedback to ensure we are listening to the voices of our ethnic minority communities
- Developing cultural awareness training in partnership with ethnic minority communities to support inclusion across the ICSD
- Developing and improving translation services with communities to ensure everyone is able to access the healthcare they need
- Building a more diverse workforce that represents our local ethnic minority communities across the ICSD and ensuring equal access to progression opportunities.

Proposed merger for the RD&E and Northern Devon Healthcare Trust

Northern Devon Healthcare NHS Trust and the Royal Devon and Exeter NHS Foundation Trust are set to become a single organisation from 1 April 2022.

In February, the two hospitals submitted a full business case to NHS England, in preparation for coming together in a single, integrated organisation that would include community services, including community hospitals.

The new arrangement aims to secure the long-term sustainability and resilience of acute and other services across the populations in eastern and northern Devon.

Safe bus collaboration in Plymouth

A Safe Bus is to be found in Plymouth city centre on Friday nights, offering medical help to people who might otherwise go to Derriford Hospital's Emergency Department.

The scheme is a partnership between Plymouth City Council, the CCG's Plymouth locality, Devon and Cornwall Police and Plymouth City Bus, which provides and maintains the vehicle free of charge. Alliance Paramedic Group provides the medical assistance, ensuring paramedics are not taken away from the core ambulance service. Of 144 people treated, 17 were referred onwards to the Emergency Department. The funding for the bus has now been agreed for a further 12 months. As well as Friday nights, the bus will be out for Freshers Week, the One Big Weekend Festival and at Christmas.

Eastern Locality Local Care Partnership

The Eastern Locality Local Care Partnership covers a large area in Devon ranging from Axminster to Okehampton and including Exeter – a geography and demography that present some unique challenges.

The Eastern locality has used the Local Care Partnership (LCP) to meet these challenges, partnering with the local authority, its multiple city, district and local councils, those in the wider health and care system and a broad, sometimes dispersed, range of voluntary and community organisations to develop trust-based relationships.

To develop and cement relationships and deliver different outcomes, the initial focus for the LCP is on three key prevention themes: loneliness/social isolation, unpaid carers and children's and young people's mental health. These have been identified from relevant public health data and the emerging priorities from the community conversations that have taken place.

The LCP partners held a conference in November, 2021 - *'A Good Place: working together to improve health and wellbeing and tackle health inequalities'*.

Since then, and responding to the issues raised, £1.2million in funding has been agreed to invest in the voluntary and community sector, to support a reduction in length of stay in hospital and delays in discharge as well as the priorities identified at the conference. The LCP will engage with locality organisations on enhancing or developing services to provide short to medium term demonstrable outcomes and benefit. Voluntary and community organisations, community services managers and Primary Care Networks have worked together to identify opportunities for innovation at neighbourhood level, including skills and training gaps and infrastructure development.

Oxygen at home

Working collaboratively with home oxygen supplier Air Liquide Healthcare and the Royal Devon & Exeter Hospital, the CCG implemented a trial within the respiratory ward to support the timely discharge of patients in need of oxygen by loaning two transportable oxygen concentrators that can be sent home with the patient.

A trial started in February 2022 and it is hoped the scheme will avoid unnecessary delays in patients being discharged, since they will no longer need to wait for equipment to be installed in their home. Facilitating a fast-tracked discharge will bring efficiencies to both the RD&E and Air Liquide, which will be able to plan the installation of the full equipment into the home the next day rather than within 4 hours of an order being raised, something that raises an additional cost to the NHS.

Commitment to wellbeing in Exeter

The University of Exeter has signed a landmark Civic University Agreement with city partners – the first in the South-West – to improve opportunity, prosperity, wellbeing and the environment for local communities.

Following local consultations, Exeter City Council, the Royal Devon and Exeter NHS Foundation Trust, Exeter College and the University of Exeter have set out their joint mission to drive progress in five areas:

1. Sustainable and inclusive growth
2. Delivering a net zero Exeter
3. Aspiration and opportunity
4. Culture and tourism
5. Health and wellbeing

Care hotels partnership to reduce delayed discharges

To avoid people waiting in hospital for packages of care or placements to become available, the Plymouth locality partnered with Abicare to establish three patient hotels.

Local hotels were commissioned to provide the accommodation and Abicare provided oversight and management, under its registration with the CQC for domiciliary care in a hotel setting.

This assisted the flow of patients who were ready to leave hospital, and made 8,600 bed days available. The hotels also provided emergency accommodation for people in a care home damaged by Storm Eunice in February.

Wellbeing was promoted through activities for residents and the carers maintained close links with therapy teams and family visitors. Feedback from patients has been overwhelmingly positive.

Digital strategy

A digital revolution is happening in healthcare, and the adoption of new technologies continued to develop at pace during the year.

Prominent among these has been work on the Devon and Cornwall shared care record, which brings together patient data from a wide range of clinical systems and presents it as a single view.

This means that a health and care worker in a GP practice, hospital, hospice or care home can see vital information about a patient they are caring for.

The shared care record will, over time, be expanded in range to include a greater amount of information, including images, radiography, allergies, laboratory results and correspondence, as well as diagnoses, medications, health conditions and procedures.

This will improve decision making and benefit patients in receiving greater continuity of care.

The work is a key part of partnership working across the peninsula, and forms part of the Digital Blueprint agreed by Devon partners.

Other work included:

- Re-procurement of online consultation and video consultation for primary care (see below page 24)
- Implementation of the Digital Locum for primary care, which allows GP practices to use locums remotely. Training for the primary care workforce bank was completed in

mid-February, and the pilot has attracted 4.4 stars out of five in feedback from practices. The Digital Locum has provided the practices taking part with more than 6,000 extra clinical hours.

- Implementation of the NHS-approved ORCHA app platform, which provides safe, accredited compliant healthcare libraries, helping accurate prescription for patients

In other digital developments, Torbay and South Devon NHS Foundation Trust along with a small group of other hospital Trusts has worked with NHS Digital as a national pilot centre for trialling the ground-breaking Microsoft HoloLens 2 and Dynamics 365 Remote Assist.

A mixed reality headset, HoloLens 2 uses multiple sensors, advanced optics, and holographic processing. The digital overlays created within the headset can be used to display information which blends with the real world to create a mixed or augmented view.

The first pilot project is taking place at Torbay Hospital's Breast Care Unit, where the digital technology will support nurse-led dressing clinics. Clinical specialist nurses will be able to send a high-resolution video feed to consultants, in real time, to get immediate feedback and advice on a patient's needs. Additionally, consultants are able to add digital markers and annotations live on to the video, to guide the nurse's view where useful. This replaces the current system of emailing static images to consultants.

Primary care

GP patient survey

Devon GP practices once again won endorsement from their patients in the 2021 national patient survey. See page 3 for more details.

Primary care developments

Primary care in Devon continues to implement its five year strategy. Primary Care Networks are now well established, bringing together GP practices in given areas to work together for the benefit of patients. In each Local Care Partnership, a Primary Care Collaborative Board brings together all the Primary Care Network clinical directors, for discussion about priorities and decision making.

The vision set out in the strategy is that primary care in Devon will offer each local community a wide and flexible range of information, support and services to enable people to live happy healthy lives.

To do this, we must address a number of challenges. Increasing demand, difficulties in recruitment and retention, and funding that includes estates and IT are areas that need our attention. The strategy therefore outlines five priorities that will revolutionise general practice.

1. We will improve patient access to care through innovative technology
2. We will develop and retain an agile and engaged workforce, with a focus on multi-disciplinary teams to reduce pressures on services and improve outcomes for patients.
3. We will take a population health management approach to improve Devon's health and wellbeing, and reduce health inequalities

4. We will develop Primary Care Networks to provide more joined-up care close to home
5. We will modernise our estates and infrastructure to support and enhance services.

These five priorities are being built into the Devon Long Term Plan, to be executed by the Integrated Care System for Devon from 2022.

With the onset of the COVID-19 pandemic, the way in which general practice services were delivered had to change almost overnight. Devon has been fortunate in having a group of innovative practices which had already started to introduce online consultations and improved digital tools, so that for many the technology needed was already in place. However, the rapid move to increased remote working was still a challenge to practices across the country.

To limit exposure to the virus and keep both patients and staff safe, practices have continued to implement infection control measures. These include social distancing, enhanced cleaning procedures and use of personal protective equipment (PPE). It takes time for general practice to carry out the necessary cleaning and change of PPE required between face-to-face contacts, and this has an inevitable impact on the numbers of people that clinicians can see each day.

GP practices use remote screening for patients before they attend and, in most cases, initial consultations have been taking place remotely so a patient's individual needs can be assessed and triaged – either by telephone, video or online. Once triage has taken place, people can be seen face to face where clinically appropriate. This is arranged in every one of the practices in Devon.

In addition, urgent care has continued to be prioritised so that people can be confident that their most urgent needs will be met.

By the early months of 2022, GPs and their teams had delivered 700,000 doses of the COVID-19 vaccines.

As England emerged from restrictions to people's activities, new and increasing demand added significant pressure to general practice.

Local GPs saw significant increases on pre-pandemic levels of contact by patients and the volume of calls has meant that GPs and other practice staff have been working through long lists of requests for consultations every day. This has had an impact on telephone waiting times.

GP practices in Devon have provided a staggering 4.7 million face to face appointments over the last 12 months – that's almost 400,000 per month - 2.7 million telephone consultations and 700,000 online consultations.

Digital developments in primary care

Primary care in Devon has continued to develop and mature digitally. The year has seen both new technology being implemented and the consolidation of the technology deployed at pace as part of the pandemic response the year before.

All of Devon's 121 practices now offer online and video consultation to their patients. With the number of online consultations carried out, patient satisfaction has remained high. We have also seen a further increase in the use of SMS text messages by practices, for everything

from appointment reminders to patient questionnaires, or patients sending in pictures of their conditions.

With Devon now reaching the end of its existing contracts for online and video consultation, we have undertaken a significant piece of engagement work with practices, patients and stakeholders to understand the future requirements in Devon. We are currently in the process of procuring replacement contracts for these services based on the engagement undertaken and for the first time are offering a choice of system to practices.

The digital team and CCG digital providers have continued to support general practices vaccination programmes, with both technical support, systems and devices. We have also supported general practice staff to work more effectively from home when required, with additional laptops and alternative means of remotely accessing systems. To further support GP practices, we have made specialist cyber security training available to them and invested in more digital communications capacity.

By the end of May 2022 every practice in Devon will have moved to Microsoft Office 365 providing them with a suite of fit for purpose up-to-date software, with both updated traditional office capabilities, but also new useful tools to support the management and running of general practice.

To further pave the way for future digital work, we have undertaken a joint project with Plymouth City Council, sponsored by the Department for Digital, Culture, Media and Sport to install fibre-optic connections to 48 general practice sites in West Devon. We have also upgraded some of the core network infrastructure across the county, increasing its resilience and laying the bedrock for future advancements.

Use of the NHS App has continued to increase in Devon with 432,000 registrations, accounting for 40% of the patient population aged over 13.

Winter

Winter sees increased demand for NHS and social care services. This winter, compared with last, saw fewer hospitalisations from COVID-19, as increasing numbers in all age groups were taking up vaccination against the virus.

Nonetheless, all parts of the health and care system witnessed greater pressures, with the big district hospitals reaching OPEL 4 at some stage - the highest level of pressure.

However, with advanced planning under the Integrated Care System for Devon, the system collaborated more closely than ever to permit timely discharges from hospital. It also continued a campaign to promote use of the NHS 111 service as an alternative to presentation at hospital emergency departments.

Winter preparedness and delivery of plans remains a standing item on local and Devon A&E delivery boards to underpin strong system working across organisations.

Looking ahead – our plans for 2022/23

COVID-19 pandemic

A continuing system-wide response to the coronavirus pandemic will remain a priority for the Devon healthcare system in the year ahead, with planning for a response to further variants and continued vaccination programmes running alongside strategic planning.

In the immediate term, a focus will be on delivering the vaccination programme for those in the over 85 age group, who will receive a further dose from April 2022.

The CCG continues to remain vigilant, with measures to minimise risk for both patients and its workforce. Home working, where appropriate, will continue to be in place.

Integrated Care System for Devon (ICSD)

The year from 1 April 2022 will see the biggest change in the healthcare system in Devon since clinical commissioning groups were established in 2012. All the functions of NHS Devon CCG will be absorbed into the new Integrated Care System for Devon.

Working in shadow form until 1 July 2022 under the leadership of Jane Milligan as chief executive, the ICSD will focus on improving health and social care for the people of Devon, while also attending to improving performance of the system.

The new ICSD NHS body will be made up of commissioners with providers on the Board. An ICSD Health and Care Partnership will include local authorities, Health and Wellbeing Boards, Healthwatch and voluntary and independent sector partners.

Digital strengthening

Digital technology has moved more quickly than ever in the past two years, and we will continue to strive for innovation and efficiency.

The Devon and Cornwall shared care record will be an area of great focus, affording the opportunity to improve patient safety and experience as well as aiding decision making.

Performance summary

A summary and perspective by Jane Milligan, Accountable Officer for NHS Devon CCG:

Whilst we have continued to work closely with providers to make improvements against our key targets (including those set out in the NHS Constitution) 2019/20 was a mixed year for performance with progress in some areas balanced out by continued challenges in others.

The CCG continues to perform well on measures of early diagnosis of cancer and cancer survival rates, whilst there was also sustained good performance against the range of mental health targets. We continued to score highly against patient experience measures and, looking at quality of care, again saw low rates of healthcare acquired infections.

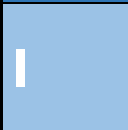
However, there were other areas that were a greater challenge. Performance against the A&E 4-hour wait measure was below target although there was good progress in reducing delayed transfers of care and patients spending a long time in a hospital bed. Performance

deteriorated against the 18-week referral to treatment target, but over one-year waits decreased in quarter four whilst the 6-week diagnostic wait targets remained a particular challenge but also showed improvement in quarter four. For all targets where there are underperformances we are working with our provider colleagues to ensure recovery plans are in place, with clear actions and impacts

The Strategic outcomes framework (SOF) draws together in one place NHS Constitution and other core performance and finance metrics, outcome goals and transformational challenges, to capture the multi-faceted role of CCGs.

SOF are updated and released on a quarterly basis, with the SOF published through a range of channels including NHS futures

The latest information available for 2021/22, where data was published for 53 indicators for the Devon ICS area,

	CCG		ICS	MH provider	Provider
Highest performing quartile		1	9	0	1
Interquartile range		13	18	0	9
Lowest performing quartile		1	5	1	2

NHS OF Metric Name	Period	CCG	ICS	1H Provide	Provider
S001a: Appointments in general practice	w/e 30/01/2022	161,493			
S005a: Daily discharges - as % of patients who no longer meet the criteria to reside in hospital	16/01/2022		35.90%		
S008a: Overall size of the waiting list	2021 11		143,695		
S009a: Patients waiting more than 52 weeks to start consultant-led treatment	2021 11		12,471		
S010a: Cancer - first treatments	2021 11		820		
S010b: Cancer - urgent referrals seen	2021 11		2,444		
S011a: Cancer - people waiting longer than 62 days	w/e 30/01/2022				645
S012a: Cancer - % meeting faster diagnosis standard	2021 11		70.50%		
S013a: Diagnostic activity levels - Imaging	2021 11	24928			26198
S013b: Diagnostic activity levels - Physiological measurement	2021 11	2208			2259
S013c: Diagnostic activity levels - Endoscopy	2021 11	2590			2735
S014a: Cancer - proportion of people that survive cancer for at least 1 year after diagnosis	2018		75.40%		
S017a: Outpatient - % of all activity delivered remotely via telephone or video consultation	2021 10				23.30%
S019a: Ambulance handover delays greater than 30 minutes (as reported by NHS Acute Trusts)	2021 03				1,119
S021a: Maternity - % women on continuity of care pathway	2021 10		85%		
S022a: Maternity - number of Stillbirths per 1,000 live births	2019		3.43 per 1,000		
S023a: Maternity - number of neonatal deaths per 1,000 live births	2019		1.44 per 1,000		
S026a: Proportion of ED patients who turn up unheralded	2022 01		96.40%		
S029a: Reliance on specialist inpatient care for adults with a learning disability and/or autism	21-22 Q2		39 per 1,000,000		
S030a: Percentage of people aged 14+ on the GP learning disability register receiving an annual health check	21-22 Q3	35.20%			
S031a: Number of personalised care interventions	21-22 Q2		40,008		
S032a: Personal Health Budget	21-22 Q2		5,455		
S033a: Social Prescribing unique patient referrals	21-22 Q2		11,607		
S037a: Patient experience of GP services	2021		87.90%		
S039a: National Patient Safety Alerts not completed by deadline	2022 01				4
S040a: Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infections	2021 12	1			0
S041a: Clostridium difficile infections	2021 12	22			12
S042a: E. coli blood stream infections	2021 12	69			22
S044a: Antimicrobial resistance: appropriate prescribing of antibiotics in primary care	Dec 2020 - Nov 2021	78.20%			
S044b: Antimicrobial resistance: appropriate prescribing of broad spectrum antibiotics in primary care	Dec 2020 - Nov 2021	976.70%			
S045a: COVID-19 - % adults vaccinated	w/e 12/09/2021		93.40%		
S046a: Population vaccination coverage - MMR for two doses (5 years old) to reach the optimal standard nationally (95%)	21-22 Q2	92.60%			
S047a: Percentage of people aged 65 and over who received a flu vaccination	2021 11	81.10%			
S050a: Cancer - cervical screening coverage, females aged 25-64, attending screening within target period	21-22 Q1	75.40%			
S051a: Number of people supported through the NHS Diabetes Prevention programme	21-22 Q3		37.70%		
S052a: Diabetes patients that have achieved all the NICE recommended treatment targets (adults and children)	2020-21	32.90%			
S055a: General Practice Referrals to NHS Digital Weight Management Programme - Crude Rate/100,000 population	21-22 Q3	5 per 100,000			
S067a: Leaver rate	2021 11		12.50%		
S068a: Sickness absence (working days lost to sickness)	2021 09		5.69%		
S070a: Number of people working in the NHS who have had a flu vaccination	2021 11			29.8%	60.3%
S073a: Nursing vacancy rate	2021 12				6.7%
S081a: IAPT access (total numbers accessing services)	21-22 Q2		6,350		
S082a: IAPT recovery rate (%)	21-22 Q2		100%		
S083a: Estimated diagnosis rate for people with dementia	2021 12		56%		
S084a: Children and young people (ages 0-17) mental health services access (number with 1+ contact)	2021 11		11,740		
S085a: People with severe mental illness receiving a full annual physical health check and follow up interventions	21-22 Q3		3,643		
S086a: Inappropriate adult acute mental health Out of Area Placement (OAP) bed days (internal or external)	Sep 2021 - Nov 2021		2,665		
S086b: Inappropriate adult acute mental health Out of Area Placement (OAP) bed days (external only)	Sep 2021 - Nov 2021		1		
S087a: Rate per 100,000 population of people in adult acute mental health beds with a length of stay over 60 days	2021 11		50 per 100,000		
S087b: Rate per 100,000 population of people in older adult acute mental health care with a length of stay over 90 days	2021 11		7.5 per 100,000		
S088a: Number of women accessing specialist community perinatal mental health services	Dec 2020 - Nov 2021		8.0%		
S089a: Waiting times for Urgent Referrals to Children and Young People's Eating Disorder Services	Jan 2021 - Dec 2021		61.0%		
S089b: Waiting times for Routine Referrals to Children and Young People Eating Disorder Services	Jan 2021 - Dec 2021		44.2%		

The latest information available for 2021/22, where data was published for 34 indicators at provider level,

		NDHT	RDEFT	TSDFT	UHP
Highest performing quartile		16	10	5	9
Interquartile range		8	18	18	15
Lowest performing quartile		10	4	9	9

NHS OF Metric Name	Period	NDHT	RDEFT	TSDFT	UHP
S005a: Daily discharges - as % of patients who no longer meet the criteria to reside in hospital	16/01/2022	27.20%	45.30%	32.50%	32.10%
S008a: Overall size of the waiting list	2021 11	17,340	66,194	32,216	39,739
S009a: Patients waiting more than 52 weeks to start consultant-led treatment	2021 11	1,235	6,288	2,146	2,855
S010a: Cancer - first treatments	2021 11	79	315	177	376
S010b: Cancer - urgent referrals seen	2021 11	718	2,162	1,602	2,379
S011a: Cancer - people waiting longer than 62 days	w/e 30/01/2022	137	177	206	125
S012a: Cancer - % meeting faster diagnosis standard	2021 11	39.30%	83.80%	53.80%	78.10%
S013a: Diagnostic activity levels - Imaging	2021 11	3,028	7,520	5,183	10,467
S013b: Diagnostic activity levels - Physiological measurement	2021 11	339	-	684	1,236
S013c: Diagnostic activity levels - Endoscopy	2021 11	364	729	837	805
S017a: Outpatient - % of all activity delivered remotely via telephone or video consultation	2021 10	26.50%	23.90%	15.50%	26.10%
S019a: Ambulance handover delays greater than 30 minutes (as reported by NHS Acute Trusts)	2021 03	33	48	118	920
S021a: Maternity - % women on continuity of care pathway	2021 10	85%			
S022a: Maternity - number of Stillbirths per 1,000 live births	2019	3.13 per 1,000	3.37 per 1,000	2.74 per 1,000	4.07 per 1,000
S023a: Maternity - number of neonatal deaths per 1,000 live births	2019		1.56 per 1,000		1.02 per 1,000
S026a: Proportion of ED patients who turn up unheralded	2022 01	93.50%	94.40%	996.80%	99.20%
S034a: Summary Hospital-Level Mortality Indicator	2021 09	105.30%	95.90%	105.70%	118.40%
S035a: Overall CQC rating (provision of high-quality care)	2022 01	2 - Requires Improvement	3 - Good	3 - Good	2 - Requires Improvement
S036a: NHS Staff Survey Safety culture theme score	2020	6.89/10	6.74/10	6.63/10	6.79/10
S039a: National Patient Safety Alerts not completed by deadline	2022 01	4	0	0	0
S040a: Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infections	2021 12	0	0	0	0
S041a: Clostridium difficile infections	2021 12	0	2	4	6
S042a: E. coli blood stream infections	2021 12	1	5	6	10
S059a: CQC well-led rating	2022 01	2 - Requires Improvement	3 - Good	3 - Good	3 - Good
S062a: NHS Staff Survey Health and wellbeing theme score - Health and well-being index	2020	6.36/10	6.19/10	6.06/10	6.08/10
S063a: NHS Staff Survey Safe environment - Bullying and harassment theme score	2020	8.3/10	8.31/10	8.08/10	8.15/10
S064a: Proportion of staff who report that in the last three months they have come to work despite not feeling well enough to perform their duties	2020	39.80%	44%	46.50%	47.80%
S065a: Percentage of staff who say they are satisfied or very satisfied with the opportunities for flexible working patterns	2020	60.70%	52.60%	55.60%	52.20%
S067a: Leaver rate	2021 11	14%	15.90%	13.50%	12.50%
S068a: Sickness absence (working days lost to sickness)	2021 09	4.74%	5.35%	5.38%	6.32%
S069a: NHS Staff Survey Staff engagement theme score	2020	7.28/10	7.08/10	6.98/10	6.93/10
S070a: Number of people working in the NHS who have had a flu vaccination	2021 11	63.10%		61.30%	58.40%
S072a: Proportion of staff who agree that their organisation acts fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age	2020	87.60%	87.30%	85.20%	84.80%
S073a: Nursing vacancy rate	2021 12	10.70%	3.34%	9.86%	6.41%

Performance analysis

NHS constitution targets

The NHS constitution sets out key targets for NHS organisations. In 2021/22 many services were affected by the COVID-19 pandemic, resulting in large increases in waiting lists and waiting times in many areas, particularly following the first wave. Throughout the pandemic those patients with the greatest clinical need for hospital treatment were prioritised and when pressure on services relaxed, services were restored as quickly and as safely as possible. However, continuing pandemic pressures have resulted in the majority of constitutional performance targets being missed. Despite this, some areas have seen an improvement and there has been significant benefit realised from improvements in technology that have increased the number of patients being able to be treated in a different care setting or in their own homes via video consultations.

While joint mutual support arrangements were already in place and working well across the Devon system, even closer joint working between organisations has been an important element of the pandemic response, enabling support to be offered between organisations where this helped to address capacity gaps or support priorities of the COVID-19 response. Lessons learned from the pandemic response will be hugely helpful in planning and delivering the recovery of performance in 2021/22 and beyond.

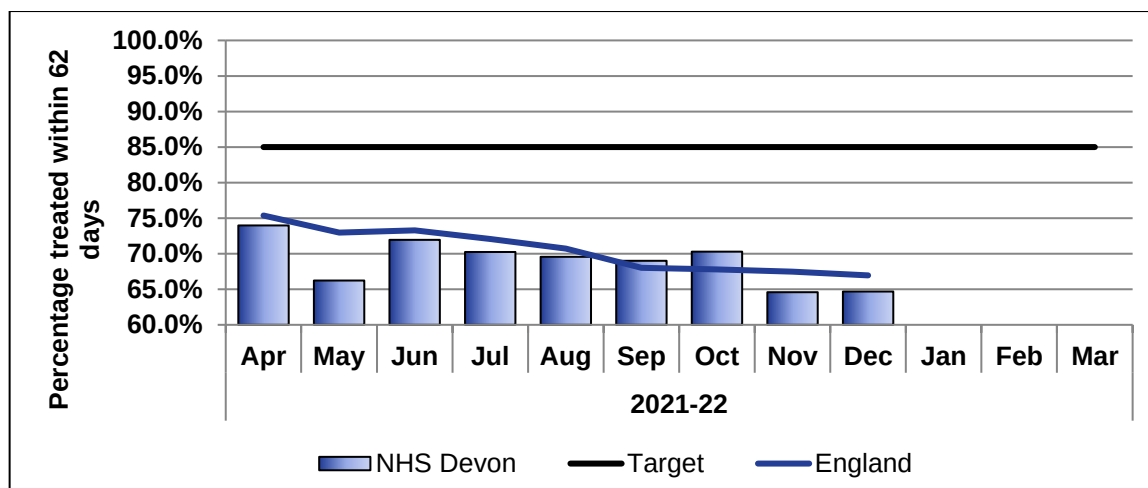
Work on the recovery of performance is gathering pace, with dedicated theatre space being provided and a programme to tackle the backlog of people whose treatment has been delayed.

More detail regarding 2020/21 performance against each of the key national standards is provided below.

2021-22 YTD (December position)							
KPI	Target	NHS Devon	RDEFT	NDHT	UHP	TSDFT	England
Referral to treatment - Percentage treated within 18 weeks - Incomplete Pathways	92%	55.1%	50.6%	59.6%	62.0%	55.7%	66.4%
Number of over-52-week waiters (as at December)	0	12578	6128	1316	2980	2383	n/a
Diagnostic waiting times - Percentage treated within 6 weeks	99%	64.0%	65.2%	42.1%	73.2%	66.7%	75.0%
Accident and emergency percentage seen within four hours (acute only)	85%	63.9%	64.8%	76.2%	n/a	42.7%	71.9%
Accident and emergency percentage seen within four hours (All)	95%	75.6%	74.6%	76.2%	n/a	68.6%	80.3%
Cancer - Percentage treated within 2 weeks	93%	72.0%	68.9%	79.5%	82.1%	60.7%	83.2%
Cancer - Percentage treated within 62 days - urgent referral to first definitive treatment	85%	68.9%	64.9%	72.0%	70.9%	69.3%	70.4%

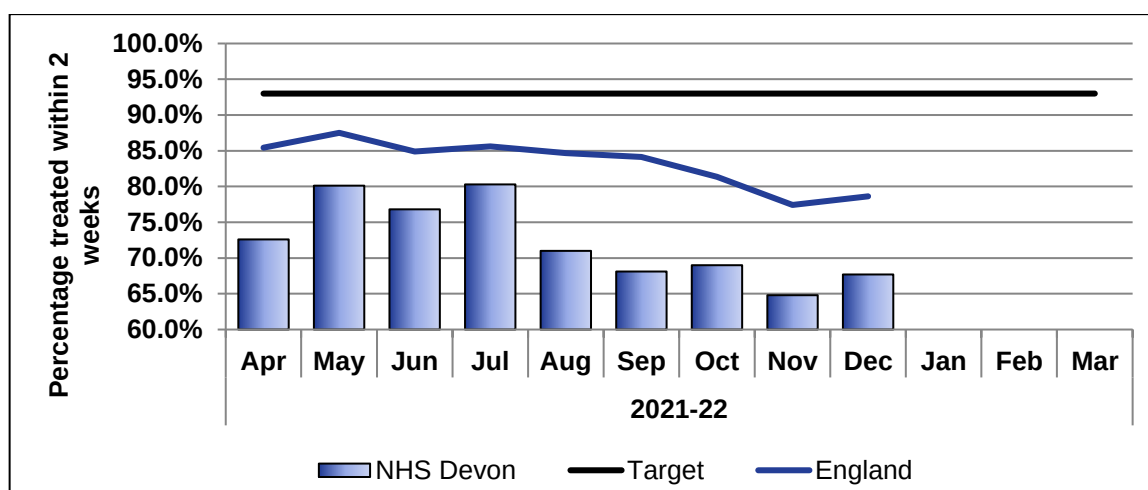
Cancer - percentage treated within 62 days - urgent referral to first definitive treatment

Throughout the pandemic cancer services remained active and although under the national target the CCG position has remained close to the national average for the majority of the year. As of December 2021, the CCG saw 65% within 62 days slightly below the national average of 67%.



Cancer - percentage seen within 2 weeks – urgent referral to first seen

The CCG performance remained below the national 93% target throughout the year at 68% and below national average of 78%. Staffing levels were a significant challenge, with Covid-related absence and self-isolation requirements having an impact. Providers followed national guidance to enable urgent cancer services to continue through the pandemic, aided by the mutual support process led by the Cancer Alliance.



Other cancer targets

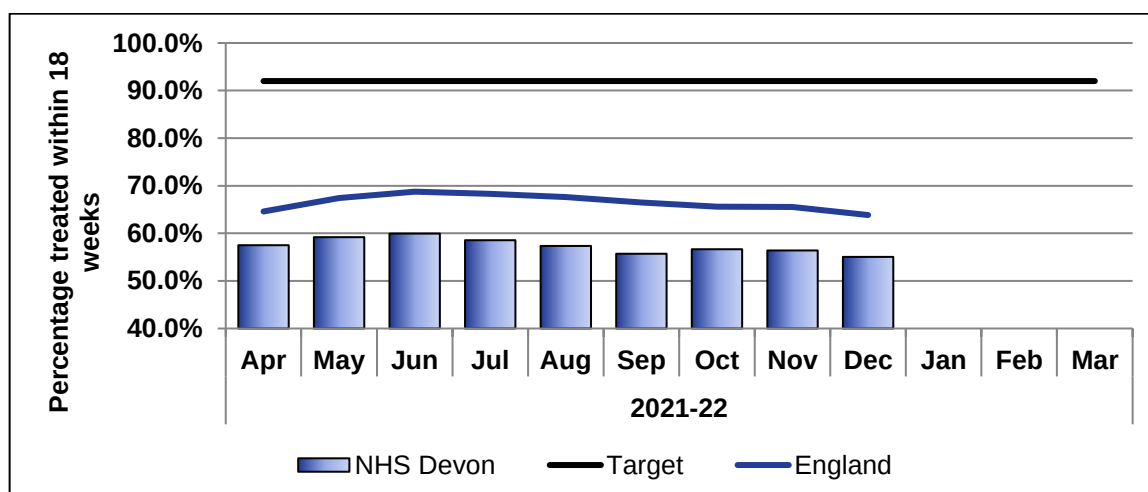
Performance was poor against other cancer waiting times targets with two of the seven standards. The CCG continues to work closely with providers to review cancer pathways and identify opportunities for reducing delays. Cancer breaches are reviewed on an individual basis so that lessons learned can be applied to ensure future improvement.

Description	Target	2021	Q1	Q2	Q3	Q4	2022
Cancer - seen within 2 weeks - urgent referral to first seen	93%	82%	76.4%	73.1%	67.1%		72.0%
Seen within 2 weeks - referral of any patients with breast symptoms	93%	64%	22.5%	46.4%	31.1%		32.3%
Cancer - treated within 62 days - urgent referral to first definitive treatment	85%	77%	71.2%	69.6%	66.3%		68.9%
Cancer - treated within 62 days - referral from NHS Cancer Screening Programme	90%	82%	71.1%	61.5%	70.2%		67.4%
Cancer - treated within 62 days - consultant upgrade	85%	84%	78.1%	76.1%	74.9%		76.3%
Cancer - treated within 31 days - decision to treat to first definitive treatment	96%	98%	96.6%	94.7%	93.8%		94.9%
Cancer - receiving subsequent treatment within 31 days – surgery	94%	91%	88.3%	88.2%	85.3%		87.2%
Cancer - receiving subsequent treatment within 31 days – drug	98%	100%	99.7%	99.3%	99.4%		99.4%
Cancer - percentage receiving subsequent treatment within 31 days – radiotherapy	94%	97%	98.9%	98.3%	98.6%		98.6%

KEY	
GREEN: PERFORMING	on or above target
AMBER: AT RISK	5% below target
RED: UNDERPERFORMING	More than 5% below target

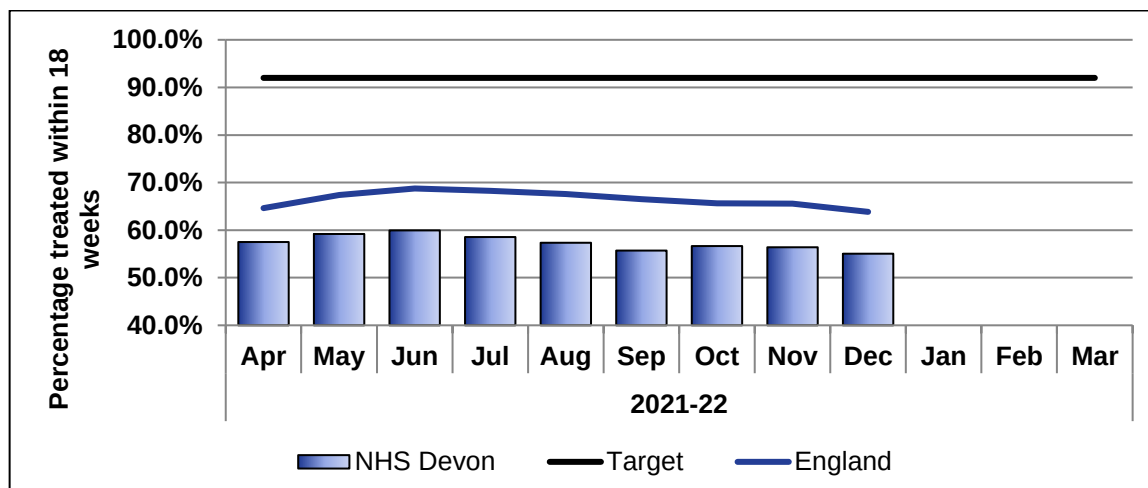
18-Week referral to treatment (RTT)

Due to many hospital services being suspended or reduced during the Covid-19 pandemic, waiting times for treatment have escalated and although the majority of services were quickly restored, they have been at a reduced level. The CCG saw 55% of patients within 18 weeks compared to a national average of 64% and over one-year waits increased from 124,332 in April 2022 to 143,375 patients by December 2022. However, patients continue to be prioritised by clinical need and system-wide plans are being developed to address the backlog of long patients and to reduce the overall size of the waiting list.



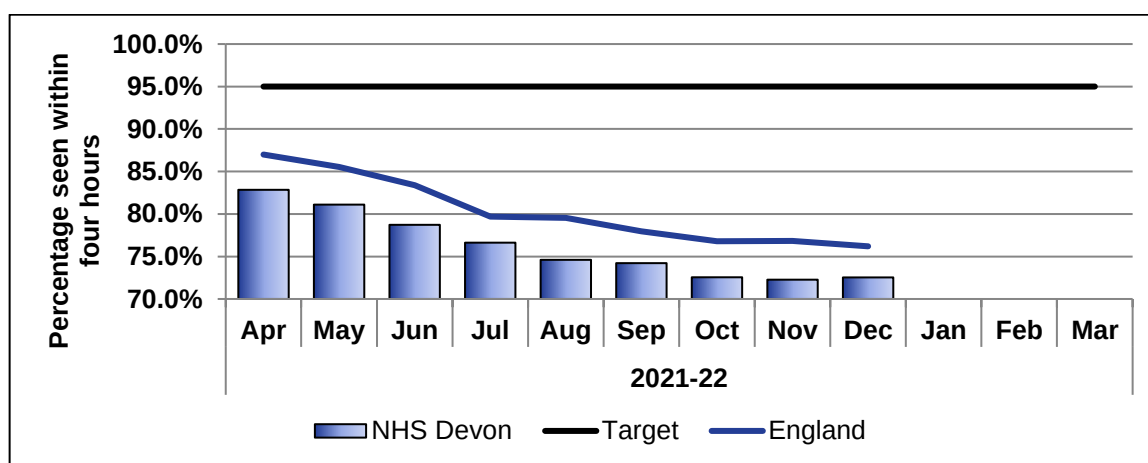
6-Week diagnostic waits

Diagnostics services were also reduced during the pandemic to support the Covid-19 response. Providers have now increased diagnostic testing and performance rates remain low at 60.7% within 6 weeks below the national average of 71%. Main pressure areas continue to be imaging (mainly CTs and MRIs), endoscopies and echocardiograms.



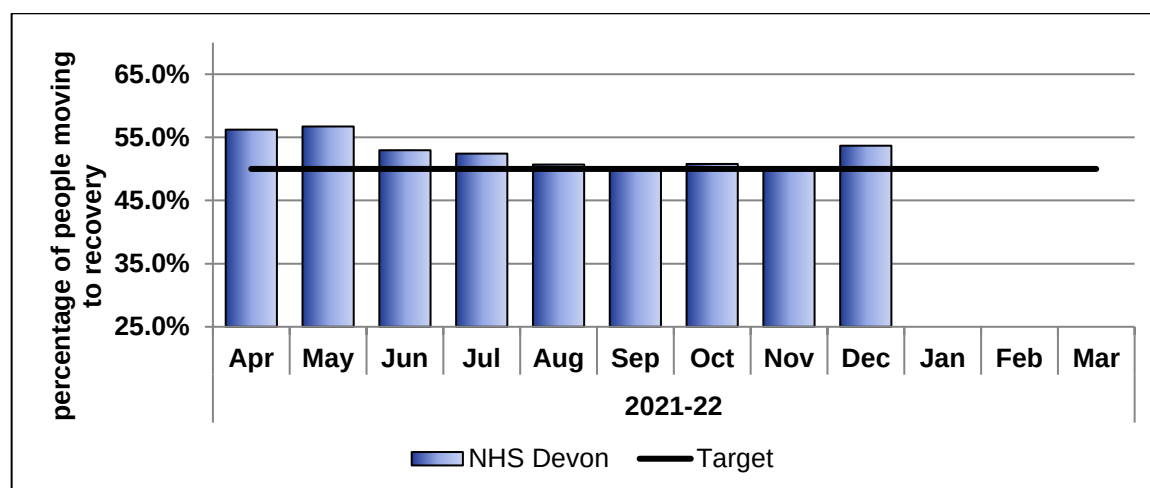
A&E 4-hour waits

A&E performance was below the 95% target at CCG level during 2021/22 with all providers in Devon struggled to meet this target, reflecting the deteriorating national position.



Mental health - improving access to psychological therapies (IAPT) access and recovery rate

The IAPT recovery rate is linked to the profile of the patients accessing treatment. Those patients with lower level needs often have a higher recovery rate than the more complex cases. The CCG has performed well against this target in 2021/22, achieving the 50% threshold throughout the year.



NHS 111 Service

Performance against the non-emergency calls being answered in 60 seconds measure has seen a significant decrease from 64% in April to 24% in November, reflecting the decline in the national position of 27%. The recent introduction of the national Think 111 campaign has resulted in an increased volume of calls and has result in a reduction in calls meeting the target, although it should reduce the level of A&E attendances.

Performance monitoring

The CCG continues to closely monitor performance against a large range of performance and quality standards. Regular detailed reports, dashboards and analysis are reviewed by the Governing Body and supporting committees, whilst a monthly system performance group chaired by the CCG and attended by providers and regulators assesses the latest performance information and reviews exception reports and action plans to improve performance where required. Work is underway to integrate reporting of population outcome measures (the 'health of the population'), performance, quality and finance, which will provide a more rounded view of system outcomes.

For key constitutional or operational targets any significant risks to performance are entered onto the CCG risk register and reviewed monthly by the senior team to ensure operational and clinical risk is understood and actions are in place to reduce this risk.

Sustainable development (environmental matters)

Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. Spending money well and considering the social and environmental impacts is enshrined in the Public Services (Social Value) Act (2012). We acknowledge this responsibility to our patients, local communities and the environment by working hard to minimise our carbon footprint. Along with a number of public sector organisations in Devon, the Governing Body declared a climate emergency in 2019 and the CCG is represented at the Devon Climate Emergency Response Group.

We have an Environmental Policy approved by our Governing Body in January 2020. The policy sets out our commitment to maintain and improve the economic and social wellbeing of our staff and the health of the population by contributing towards sustainability. It will be need to be reviewed and revised to ensure it links to the system wide ICS Green Plan which will be in place from April 2022.

NHS England/Improvement have asked that all ICSs have a system wide Green Plan by April 2022. Our inaugural Green Plan will be a high level, strategic 'living' document and as the ICS and ICB develop, and work programmes become clearer, the areas of focus of the Green Plan will be developed, and sustainability will be embedded as business as usual.

The ICS Green Plan will concentrate on the following areas:

- Workforce and system leadership
- Sustainable models of care
- Digital transformation
- Travel and transport
- Estates and facilities
- Medicines
- Supply chain and procurement
- Food and nutrition
- Adaptation

We have already been making significant reductions in our carbon footprint. For example, in the last year, the reduction in miles claimed by our staff (reduced by 791,831 miles) is the equivalent of approximately 120 return journeys to New York. This equates to the planting of an additional 175,000 trees. Actions like this are vital as the ICS must decrease its carbon footprint by approximately 15% per year, year on year, if it is to achieve the national target of 80% reduction by 2028 – 2032.

Climate Change Act target

In order to embed sustainability within our business it is important to explain where sustainability features in our process and procedures.

Providers are required under contract to take all reasonable steps to minimise adverse impact on the environment, to maintain a sustainable development plan and to demonstrate progress on climate change adaptation, mitigation and sustainable development, including performance against carbon reduction management plans.

The Emergency, Preparedness Resilience Response (EPRR) responsibilities require the CCG to not only assure itself that the services it has commissioned for the population of Devon have plans in place to respond to and recover from emergencies, but that it also has its own plans in place. NHS England has a process in place to check this is the case, requiring NHS commissioners and service providers to complete an annual self-assessment.

Improving quality

Quality assurance and continuous improvement

CCG functions

The CCG continues to undertake statutory and non-statutory functions. Quality Systems and Assurance processes that enable this include:

- Statutory safeguarding, quality and equality assurance (see 1.3)
- Ongoing implementation of Better Births through the Local Maternity & Neonatal System (LMNS), including the recommendations from the Ockenden Report
- Continued provision of continuing healthcare services for those with ongoing needs, ensuring that people can access the care that they need in a timely way
- Monitoring of patient safety serious incidents
- Learning from deaths
- Medical examiners
- Infection prevention and control (IPC); antimicrobial resistance (AMR), Healthcare associated infections (HCAI)
- Independent investigations (including mental health homicides)
- Regulation 28 reports
- Judicial reviews
- Controlled drugs assurance and oversight

- Complaints
- Whistleblowing and Freedom to Speak Up
- Review of provider quality accounts

Devon's 'Harm Profile':

CCG quality assurance is currently sought through CCG processes, including serious incidents, complaints and concerns, plus ongoing CCG COVID-19 groups, intelligence and relationships with system partners.

As well as the challenge COVID-19 has continued to bring to Devon's health and social care system in the year 2021- 2022, some providers continue to experience enhanced monitoring and assurance by the CCG and have CQC action plans in place to address ongoing concerns around quality and safety.

With the Devon system extremely challenged in urgent, elective, community and primary care, multiple factors contributed to this position of increased risk, including sustained urgent care activity leading to pressures in Emergency Departments and a further stepping down of some planned procedures.

Like their acute colleagues, clinicians and domiciliary workers also faced immense pressure when trying to meet the needs of these patients in primary care and community settings, and patient flow issues through the whole health and social care system continued throughout the year.

Risks were captured on the CCG risk register and monitored by the appropriate committees, to ensure ownership, mitigation and improvement.

As we have worked to becoming an Integrated Care System for Devon, the CCG recognised its statutory duties for quality, setting up systems and processes to enable effective delivery and oversight. Therefore, 'experience, safety and effectiveness' remained central from strategic to operational level. At operational level, these include:

Experience:

Patient, family and carer feedback enables the system to embed experience of care at the centre of improvement and transformation programmes including coproduction with people with lived experience.

CCG figures from 1 April 2021 – 31 March 2021 show an overall increase in patient experience reporting from the previous year, but fewer formal complaints (10 compared to 29 last year). Feedback is analysed and reflects the start of a return to normal services after services were affected during the first and second wave of COVID-19. Continuing Health Care remains a theme within patient experience.

- Formal complaints – 14
- Patient experience – 949
- PITCH* – 824

**PITCH: our health and care professionals alerting system in place across Devon and Cornwall.*

Safety:

The CCG has continued to support the commissioning of patient safety incident investigations, and these include arrangements for regional or national escalation as appropriate, ensuring compliance with national patient safety alerts, supporting safety improvement programmes and identifying a patient safety specialist. In doing so, we have been preparing for changes to the national Serious Incident Reporting System, due to take place in 2022. The Integrated Care Board will have oversight of the processes.

Effectiveness:

The CCG has continued to ensure effectiveness through processes that include the monitoring of National Clinical Audits, providers' compliance with NICE health and care guidance, quality standards and technology appraisals and Getting it Right First Time (GIRFT) reports.

Transformation and Quality Improvement:

Local transformation and improvement priorities have continued to reflect Devon's commitment to keep quality at the heart of commissioned services. These are embedded within the NHS Long Term Plan programmes (eg maternity, learning disabilities and autism, screening programmes, continuing healthcare, personal health budgets, infection prevention and control, digital transformation programmes, clinical pathways).

Safeguarding:

The CCG safeguarding team delivers the statutory functions as directed within the Care Act 2014, the Children Act 1989 and 2004, the Health of Children in Care 2015 and the counter terrorism strategy including Prevent and the Mental Capacity Act 2005. Consideration is also given to other statutory legislation linked to safeguarding which includes child sexual exploitation, domestic abuse, female genital mutilation and modern slavery. The CCG also works to the Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework 2019. Safeguarding is a high priority for the organisation.

The CCG ensures it has robust arrangements in place to provide strong leadership, vision and direction for safeguarding. The CCG has clear and accessible policies in line with relevant legislation, statutory guidance and best practice. The CCG has a clear line of accountability for safeguarding in that an Accountable Officer and Executive Lead for Safeguarding is in place. Designated health professional roles are in place as outlined in the Intercollegiate Guidance and additional safeguarding nurse capacity has been implemented to support the CCG in its role as a delegated commissioner for primary care medical services. The team has also expanded its expertise and capacity to improve the health response in Devon to interpersonal trauma and serious violence.

The integrated safeguarding team supports both health providers and multi-agency partners working at a local, strategic and national level on safeguarding issues that have an impact on the health and wellbeing of children, young people and adults. The CCG works in partnership with the police and local authorities to share the responsibility for arrangements that safeguard and promote the welfare of children and adults in Devon. It takes an active

strategic leadership role, supporting and engaging others; and implementing local and national learning, including from serious child safeguarding incidents, safeguarding adult reviews and domestic homicide reviews. The safeguarding team works in collaboration with commissioned providers to gain assurances regarding statutory responsibilities. There is regular reporting and assurance through the Safeguarding Steering Group and quarterly reports to the Quality Assurance Committee.

Developing Quality Governance:

During the transition to an Integrated Care System (ICS) and to ensure quality is maintained and improved, the CCG is developing and leading a clear and credible strategy for improving quality, reflecting experience, safety and effectiveness and reducing unwarranted variation and inequalities. This includes transformation and embedding of cultures to empower staff and enable sustained improvement.

Wrapped around this is a defined governance and escalation process for quality which ensures that risks are identified, mitigated and escalated effectively through the Devon Integrated Care Board System Quality & Performance Group (SQPG).

The Devon SQPG is providing a single framework of governance that will enable and support Local Care Partnerships collaboratively to drive improvement to quality, delivery and outcomes. The group forms a key part of the governance structure for partners to address quality and safety risks, share learning and drive improvement.

The group provides clear line of sight on performance and risk at system level to meet the following aims:

- To seek positive assurance that statutory duties are being met, concerns and risk are addressed, and improvement plans are having the desired effect
- To seek confidence in the ongoing improvement of care quality, drawing on timely diagnosis, insight and learning. This includes confident that inequalities and unwarranted variation are being met
- Ensure timely insight and intelligence sharing into opportunities for learning and improvement.
- Identify issues that need to be addressed and escalated.

Moving forward into 2022, the group will report to the ICB, and also link to the broader Integrated Care System risk management strategy, policy and procedures.

The Quality, Equality Impact Assessment (QEIA):

The QEIA process continued to be a key tool for Devon during 2021- 2022. The process was simplified and used to assess the impact of services being stepped down during the pandemic, but the QEIA panel recommenced and continued to ensure the robustness of impact assessments through a panel consisting of member organisations across the Devon health and care system, led by the CCG.

Countering fraud, bribery and corruption

We acknowledge we have a responsibility to ensure that public money is spent appropriately, and we have policies in place to counter fraud, bribery, and corruption.

We have standing financial instructions, standing orders, NHSCFA-compliant standards of business conduct policy and a counter fraud, bribery, and corruption policy to ensure probity.

We have support from an experienced independent Local Counter Fraud Specialist (LCFS) to ensure risks are mitigated and systems are resilient to fraud and corruption. The Audit and Assurance Committee receives and approves the counter fraud annual work plan and annual report, monitors counter fraud arrangements and reports on progress to the Governing Body.

We raise awareness of fraud in staff communications through regular newsletters, displays in public and staff areas, new employee induction and individual department awareness presentations from the LCFS.

Engaging people and communities

NHS Devon CCG has a strong record on community and patient involvement, which it will take forward into the Integrated Care System for Devon.

Our strategic approach to communications and engagement is to:

- Involve people in planning services and listening to them before we make decisions that have an impact on them
- Communicate about the decisions we make as effectively as we can
- Work in partnership on the way services are developed and planned and on the way in which care is commissioned to continue to drive engagement for quality improvement.

Engagement work in 2021/22 once again reflected the need for to find new and creative ways to keep discussions and involvement going with our population, in light of the COVID-19 pandemic.

These are some examples of the engagement that took place:

Re-procuring the NHS 111 and GP out of hours service for Devon

A rigorous and competitive re-procurement exercise for the NHS 111 and GP out of hours services in Devon included comprehensive engagement with our population, and patient involvement at each step of the process.

The CCG had already worked with Healthwatch in Devon, Plymouth and Torbay in 2021 and did so again in 2022 to gather the public's feedback about these services, to establish what they thought was satisfactory or good, and what needed to change. This feedback helped inform the specification for the services that was put out to tender.

Questions to bidders were based on the insight provided by those using the NHS 111 and GP out-of-hours services. Patient representatives were also involved in the final evaluation of the bids, meaning there was deep public involvement and co-design at every step of the way.

Other work with Healthwatch

- **Think 111 First: the experiences and views of targeted people in Devon (2021)**
 - Experiences of key groups, including the deaf community, when accessing NHS 111 services, and how the Think 111 First campaign has been received by those groups. This insight also informed the re-procurement of the NHS 111 service.
- **Emergency Department Survey Report (2021)**
 - feedback on why patients were attending our four emergency departments across Devon.
- **Leg ulcer treatment: experiences & views of people in Devon (2021)**
 - Detailed feedback on patient experience about the treatment of leg ulcers, after NHS Devon CCG conducted a survey. Healthwatch held interviews with leg ulcer patients to find out what went well during their treatment and what could be improved.

CCG (COVID-19 related)

- **Vaccination experience survey (2021)**
 - On site feedback gathered at vaccination pop-up sites to inform the future planning and improving patient experience of COVID vaccinations
- **Vaccination, fertility, pregnancy, and breastfeeding webinar (2021)**
 - Engaging with the Devon population to answer questions, provide assurance and guidance to encourage pregnant woman to get vaccinated
- **Patient experience of GP appointments during the pandemic (2021)**

We engaged with users of primary care to understand:

- what local people's perceptions are of being able to get the medical help they need from their GP.
- Whether their perceptions influenced their decision making and what the impact might be on the wider NHS system.
- What we can do to help peoples understanding of how they can access their GP

CCG (general)

- **Type 2 Diabetes education (2021)**

As part of reviewing the Type 2 Diabetes Education Programme and to help shape the service for the future. we wanted to hear from people who have type 2 diabetes to better understand their experiences of living with type 2 diabetes and ensure we are meeting local needs.
- **Community Mental Health Framework (2021) ('Internal' PCN focus)**

In order to agree which PCN's the model will roll out to in 2021/22 we engaged with PCN's to consider both 'need' and 'readiness'
- **Improving Community services – strategy development (2022)**

Engagement with our Citizen Panel to help inform the development of the community services strategy

CCG (Specialist)

- **Experiences of health and care in Devon for Black, Asian and Ethnic Minority communities and staff**

The Integrated Care System in Devon commissioned the engagement as an initial step in tackling the issue following local engagement work in summer 2020 on the development of an ethical framework for Devon, during which negative experiences were shared by people from ethnic minority communities about access to healthcare, while the COVID-19 pandemic placed a spotlight on health inequalities faced by people from ethnic minority communities.

Long Term Plan

- **Protected elective capacity engagement, focus groups overview**

We ran a number of focus groups with patients and staff throughout March 2022 to gather views on our initial options for creating protected elective capacity in Devon, to help minimise the number of operations or procedures that are postponed due to COVID-19 or other emergency pressures. The insight will be used to shape final plans later this year and patient involvement will continue during this important piece of work.

Our engagement platforms

Devon Virtual Voices – our Citizens' Panel

The CCG established an online panel in 2019. The Devon Virtual Voices has more than 1,700 volunteer members willing to provide views and feedback on NHS services and priorities.

Panel members represent all the various sectors of the community including gender, ethnicity, age, postcode (geography/deprivation), disability, carers and parent or guardian.

Building on the great success of the Devon Virtual Voices citizens panel there has been a move to create a more collaborative and two-way online engagement community, so the CCG has invested in a new online engagement platform.

The new platform will be the central point for all CCG/ICS online engagement and consultation and will host the new and refreshed Citizens Panel in 2022. It will look to strengthen our engagement practice even further and with added functionality such as translation options it will increase our engagement reach to the people and communities of Devon.

Healthwatch in Devon, Plymouth and Torbay

Healthwatch organisations that have come together across Torbay, Plymouth and Devon again worked closely with us through the year at a strategic and operational level. Healthwatch also produces its own, independent surveys of patient opinion and feedback, which it passes to the CCG.

In particular, Healthwatch supported the conduct of the consultation over services in the Teignmouth and Dawlish areas.

Patient Participation Groups (PPGs)

The CCG is committed to supporting Devon PPGs and work closely with Healthwatch to ensure their feedback is heard. Healthwatch provide support to PPGs as part of their statutory requirement.

Joint Engagement Forum (JEF)

The JEF is chaired by Devon County Council's adult social care team. The group is multi-agency and brings together a number of community leaders who cover a diverse section of Devon.

Living Options Devon

Living Options Devon is a specialist engagement organisation that enable the CCG to ensure those with seldom heard voices are given an opportunity to contribute to the develop of the CCG commissioning plans and decisions.

Ensuring people have a voice

Reaching seldom heard groups

The CCG actively seeks the views of a diverse range of people, recognising that for some people who can be excluded or are disadvantaged, it can be hard to get their voice heard.

In developing plans for health and care services we work with groups including: Hikmat Devon Community Interest Company

- Devon Parent Carer Voice
- Devon Senior Voice
- Intercom Trust
- Proud 2 Be
- The Carers Forum
- The Autism Involvement Group

We also work closely with:

- local authority partners on the Special Educational Needs and Disability (SEND) agenda.
- our providers who work specifically with disadvantaged groups, eg Devon Partnership NHS Trust, Shekinah Mission (homeless outreach services)

Reducing health inequalities

How the CCG has discharged its duty under Section 14 T

The CCG has worked closely with other organisations in the health, social care and voluntary sectors in 2021/22 to reduce inequalities for the population of Devon and the impact of these inequalities on their health.

Now entering its second year, the Health Inequalities (HI) programme has adapted to meet both the requirements of the evolving national health inequalities agenda and the needs of the Devon population as we gather greater insight into health inequalities within Devon. The COVID-19 pandemic continues to exacerbate existing health inequalities within Devon, putting into stark focus the importance of the system working collaboratively to address the wider determinants of health such as access to safe, stable and fit-for-purpose housing, employment and education.

Progress against a number of whole-system workstreams within our health inequalities plan has been significantly affected by:

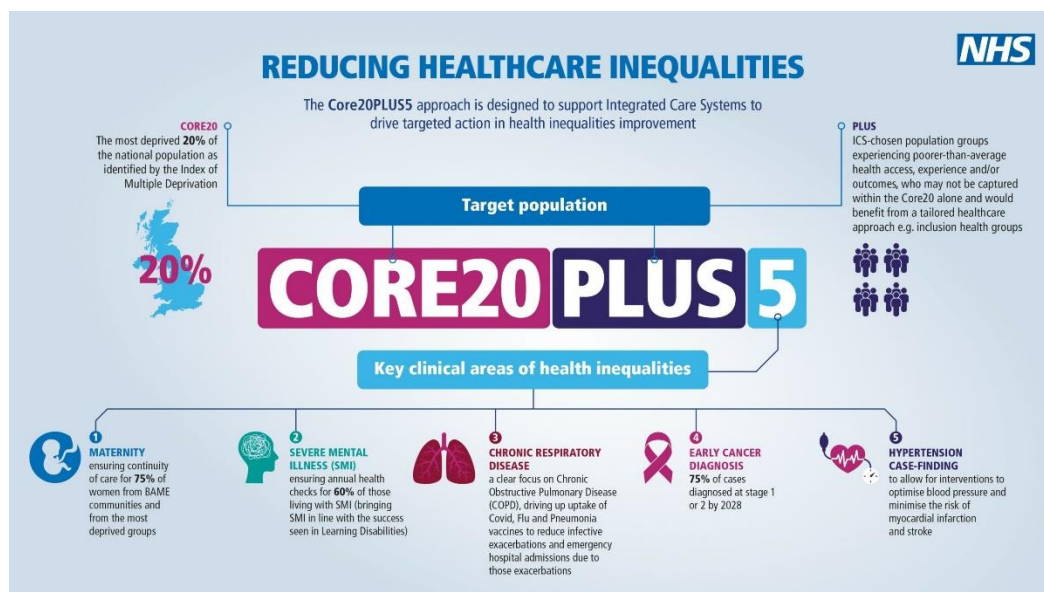
- repeated redeployment, to COVID-19 response work, of our HI team
- a lack of available capacity within our provider organisations.

Most affected have been our whole-Devon plans to address the quality and completeness of our data across all parts of the healthcare system; and our organisational development plans to raise awareness of the health inequalities agenda and embed it within everything we do.

Our cross-partner, Health Inequalities Executive Leadership Group, has overseen delivery of our work plan, meeting on a regular basis to monitor progress and share good practice and successes.

As a natural progression of last year's nationally defined 'eight urgent action themes' for health inequalities, the "CORE20PLUS5" framework now gives focus to our programme. This national framework gives emphasis to inclusion health groups known to be at greatest risk of unacceptable differences in access to and experience of health services and support, and at risk of poorer health outcomes, while also allowing us to identify other priority groups at both local and whole-Devon perspectives.

CORE20PLUS5 gives emphasis to five clinical areas known to be areas of health inequality, again allowing for locally determined priorities.



We are delighted to have received confirmation of the success of our bid to secure funding to pilot the NHSE/I “Core20Plus5 Connector” initiative, which will see us strengthen links between commissioning decisions and the inequalities experienced within local communities through the establishment of a network of health inequalities community ambassadors (“Core20Plus5 Connectors”).

It has been a very successful year in terms of securing external investment into our programme to allow us to deliver a range of targeted interventions, complimenting ongoing targeted investment of the CCG annual Prevention funding.

Through a number of funding bids and business cases, we have secured approximately £600,000 of regional and national funding to further work across a number of topics areas. We have invested both in whole-Devon activities, and supported work within specific communities.

Whole-Devon workstreams:

- Long Term Plan funding for 2.5 years for the treatment of tobacco dependence in those admitted to our acute hospitals, and women and their partners using our maternity services
- Through a voluntary sector-led test of change project, provided additional support, advice and signposting to 1,108 of our patients waiting for extended periods for planned care
- Achieving national Digital Inclusion Pioneer status for Devon, we have secured both funding, and specialist support from NHSX to better understand the digital inequalities experienced by those living in our most rural communities. This work will inform the development of a Digital Inclusion Strategy for Devon, ensuring that we consider the needs of those less confident, or practically able, to interact with our services and support using digital channels
- Short-term capacity funding to increase the resourcing of the Health Inequalities programme that has allowed us to:

- make a six-month appointment to a public health consultant of health inequalities to provide specialist input to the programme, increase the delivery capacity of the HI team, and maintain links with the work of our three local authority public health teams;
- recruit project management capacity to support the development of our Equally Well programme for mental health within our localities.

Work within specific Local Care Partnership areas:

- Expansion of the Recovery College model in Plymouth, providing additional capacity to allow 130 people with complex needs and alcohol related issues to access the support that will improve their mental health and wellbeing and increase their confidence in their own ability to self-manage their mental health problems
- Invest in additional staffing to build upon the **Alcohol Care** Team within Torbay Hospital, providing a fully functional, 5 days per week service to patients, with enhanced links to community services, mental health teams and allied health professionals
- Piloting enhanced support to patients accessing Tier 3 Weight Management Services, through a test of change project in the Plymouth system
- Building upon work already undertaken by the Plymouth Local Care Partnership, we are working with a national homeless charity to refresh our 2010 Homeless Health Needs Assessment across the whole of Devon

In addition to these focused pieces of work we have invested in, we have worked to develop the processes and culture by which health inequalities will become a consideration in everything we do. We are working across the system to ensure that we have robust mechanisms for identifying potential impact on health inequalities as we restore services following the pandemic, described below:

- Working with service providers to improve the quality of data collection
- Developing ways to join together data from a number of different sources to give a more holistic picture of health need
- Use of The Equality Delivery System tool to measure CCG performance on equality issues
- Feedback from patients through our CCG mechanisms, social media, and other media
- The Devon-wide Equality Co-operative, a forum set up to ensure a system-wide oversight of equality issues
- Regular reporting to the Quality Assurance Committee of the CCG (patient and public equality, diversity and inclusion information)
- Regular reporting to the Remuneration Committee of the CCG (workforce equality and diversity information)
- The CCG's Quality Assurance Framework

- CCG presence at Devon County Council's Joint Engagement Forum where representatives of people with protected characteristics share experience and inform commissioning developments
- Accessing to Devon County Council's Equality Reference Group (which includes members with specific protected characteristics) as a source of user experience information
- Producing an annual equality report to give assurance to our Governing Body

Revisions to our Quality and Equality Impact Assessment (QEIA) toolset are now well under way. The revised toolkit will be launched in early 2022/23, with enhancements that:

- Support our Quality Committee in offering informed, supportive, challenge to any change
- Introduces an approach that allows for greater narrative in assessing the impact of any change on people with protected characteristics where limited quantitative data is available
- Supports QEIA authors in better understanding the barriers to access, experience and outcome experienced by each group
- Describes the types of proven interventions that can be implemented to mitigate or eliminate any potential negative impact of a change, and enhance access, experience and outcomes.

The greatest risk to our programme remains a lack of good quality data relating to the protected characteristics of our population and patients. There is consensus across all system partners about the importance of addressing the issue of quality and completeness of data. However, with the system remaining under pressure, capacity within our business intelligence workforce remains focussed on other priorities. Therefore, as we conclude 2021/22, we do not have access to the full data and the required business intelligence support that allows us to:

- Refer to a baseline, up-to-date, picture of the composition of the population of Devon, particularly in relation to ethnicity
- Routinely identify the characteristics of the people who are, and importantly are not, connecting with our services to identify who may be disproportionately represented and/or underrepresented in our activity data
- Target our efforts to those experiencing unacceptable differences in access, experience and outcomes
- Be confident in understanding the impact we are having on access, experience and outcomes for those experiencing health inequalities

In light of the challenge that the lack of good quality data relating to our population and patients present us, we have promoted a “do the right thing” culture within the programme to encourage positive action while we continue to address the underlying issue of data. We carry this “can do” attitude into 2022/23 and the Integrated Care System for Devon.

Equality, diversity and inclusion

Legal duties and national standards

The CCG has a responsibility to meet a range of legal duties and standards that support equality for people who are identified as having a particular protected characteristic under the Equality Act. These characteristics are:

- Age
- Sex
- Ethnicity
- Disability
- Religion and belief
- Sexual orientation
- Gender reassignment
- Marriage and civil partnership
- Maternity and pregnancy

In addition, the CCG has identified other groups of people with characteristics that contribute towards inequality in health and these are:

- Rough sleepers (especially in relation to mental health services)
- Rural populations
- People in contact with the justice system
- Veterans and the armed forces and their families
- People affected by specific conditions or risk factors:
 - Cancer
 - Smoking
 - Learning disabilities and autism
 - Diabetes
 - Respiratory disease
 - Obesity
 - Drug and alcohol use

The duties and responsibilities include:

- The Equality Act 2010
- The Public Sector Equality Duty (PSED)
- Human Rights Act
- The Children Act
- The Workforce Race Equality Standard (WRES)
- Equality Delivery System 2 (EDS2)
- Internal equality reporting requirements

In addition, the CCG has to assure itself and the public that the organisations it commissions are meeting these requirements plus some additional standards imposed on the acute Trusts these are:

- The Sexual Orientation Monitoring Standard (SOMS)
- The Workforce Disability Equality Standard (WDES)
- The Accessible Information Standard (AIS)

The year's activity

Implementing the recommendations from Nous/ progress up to date:

- **Dedicated resource approved and recruited** to deliver EDI across the ICS in Devon. Setting out a clear **EDI strategy** for 2022/23
- Increasing **support and collaboration with the BAME staff Network**
- **System survey to all ethnically diverse staff** to encourage involvement in and development of the BAME staff Network
- Developing and implementing **reverse mentoring** schemes across the system
- Overhauling **recruitment practices across Devon.**
- Building stronger relationships with diverse communities as part of the **vaccination outreach programme.**
- Growing **visibility of significant cultural events** and traditions through calendars of cultural events eg, Black History Month, Racial Equality Week, LGBT+ History Month, Women's International Day
- **Diversifying recruitment panels** for leadership appointments including Devon ICS Chair
- New EDI and OD group to oversee system cultural development programme and the overhaul of recruitment

Increased diversity in applications from BAME groups for the new ICS NED roles

Working in partnership with the BAME staff Network Chair

- Create a strong working relationship with the Devon-wide BAME Network.
- Revamp the network to provide better engagement from members, a robust governance structure and clear aims for the network.

Events during black history month - Race Ahead campaign

- Achieving Racial Equality in Devon panel discussion event with invitees and panellists from the VCSE and Integrated Care System.
- Race Ahead– NHS Big Conversation on Race' Teams across the CCG were invited to take part in the campaign by setting time aside to discuss promoting racial equality across the NHS in Devon focusing on three topics:
 - What can I do to make a positive difference for BAME staff, patients, and communities?
 - What can we do as a team to improve the experiences of BAME staff, patients, and communities?
 - What can we do as an organisation to ensure racial equality is realised across the CCG and the Devon System?
- A presentation was given to staff as part of the CCG staff briefing and guidance was issued for teams to support the conversations. The recommended time for the session was 1.5 – 2 hours to allow for meaningful discussion.
- Following the campaign, a Summary Report was produced and shared with all staff within the CCG to show the findings and learnings from the campaign. This is available to view on the intranet.

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Celebrating diversity by marking significant cultural events

- Celebrated Racial Equality Week 2022.
- Celebrated International Women's Day March 2022.
- EDI Celebration calendar planning is in process.

Celebration of LGBT+ History Month February 2022:

- LGBT+ Panel event: Our future. Why LGBTQ+ history matters.
- Invitation to the CCG system with panel representatives from Primary Care, CCG CEO, Acute Care and the voluntary sector.
- Raising awareness of the various LGBT+ and EDI staff networks in Devon
- Social media campaign

- Celebrating the contributions that LGBT+ community make to the NHS – now and throughout history.
- Promoting LGBT+ local and national events

Recruitment to the new team

- System Equality Diversity and Inclusion Lead and Equality Diversity and Inclusion Project Manager have now been recruited into the Inclusion team.

Developed network of system EDI leads

- Bi-monthly strategy meetings.

Vaccine outreach programme

In 2021 the Devon health and social care system formed a **Health Inequalities Cell** to ensure that all eligible citizens had been offered the COVID-19 vaccine and supported to take it up because the standard means of delivering the vaccine might not be easily accessible for all communities

Detailed work had been undertaken to support specific communities including:

- Ethnic minority communities
- People who are experiencing homelessness
- Migrant workers
- Illegal immigrants and refugees
- The Gypsy, Roma and Traveller communities
- People with learning disabilities, neurodiversity and mental illness
- The LGBTQ+ community

Insight, engagement, and involvement was used to inform the vaccination programme.

We continued to work closely with our partners across the health and care system, the voluntary and community sector and community leaders to develop vaccine outreach plans, refining these as we moved through the cohorts.

Vaccine Outreach achievements:

- **Together for Devon COVID-19 vaccine social media campaign** in 11 different languages to increase vaccination in BAME communities: **total reach- 10.000**. Users have seen the ad a total of 88.000 times. Total link clicks to NHS vaccine booking system: **357**
- **Outreach Covid Vaccination Fund** that voluntary and hard to reach community organisations could bid for to fund innovative engagement activities to support the outreach vaccination model and increase engagement with vulnerable communities. 11 projects funded; eg, Devon and Cornwall Chinese Association received funding to

run a number of workshops to increase vaccination, improve vaccine knowledge, coverage and COVID-19 safety amongst the Chinese community

- Partnering with local communities and charities to increase the vaccination uptake, eg, partnership with Living Options to:
 - Deliver two focus groups on vaccine hesitancy amongst those with physical, sensory and hidden disabilities.
 - Design Deaf and Disability awareness for staff at the vaccine sites
- Visits to **Gypsy Roma Travelers** communities to offer the vaccination sessions
- CCG Devon has 20 Vaccine Ambassadors, recruited from across health and social care, local authorities, and charities since March 2021. They are trusted voices who have been promoting the Devon vaccine program to their communities
- Vaccine ambassador scheme is part of the wider outreach programme which aims to tackle health inequalities in vaccinations.
- Engagement with local groups, community leaders and the VCSE informed bespoke outreach approaches
- **338** outreach clinics providing **39,303** vaccinations
- Outreach clinics included
 - Local mosques
 - Food processing factory with large numbers of migrant workers
 - Bespoke sessions for people with learning disabilities
 - Bespoke sessions for people experiencing homelessness
 - Bespoke sessions for asylum seekers and undocumented migrants in partnership with the Red Cross
 - Mobile vaccination Unit targeted areas of deprivation
 - Partnership working with the Chinese association to deliver vaccines for the communities in 2 Devon cities
- New [films](#) featuring Devon's Vaccine Ambassadors, were launched in February 2022 to offer encouragement and reassurance to people from communities across the county who are not yet fully vaccinated.
- Filming with NHSE around the benefits of receiving the Covid vaccination- 3 vaccine ambassadors involved in the project
- The vaccine ambassador programme has been very successful – it is evidence of how **engagement can inform best practice**.
- Outreach model being rolled out to other services eg, cancer screening and diabetes
- Building relationships with communities in ways we have not done before
- Transforming inclusion across Devon with noticeable impact
- Tackling health inequalities, celebrating diversity and delivering more inclusive services that meet people's needs.

Presentation to Cabinet Office - reaching communities with lower vaccine uptake.

- Shared the Devon Vaccine Ambassador Films

Monitoring of inequalities

This has been supported through:

- Staff risk assessments (with a focus on risk assessment for staff from a minority ethnic community)
- Contributions to the development of a southwest workforce strategy.
- Establishment of a CCG staff equality group to address equality issues affecting those employed by the CCG.
- The preparation of an annual equality report to give assurance to our Governing Body
- CCG attendance at Devon County Council's Joint Engagement Forum where representatives of people with protected characteristics share experience and inform commissioning developments
- Continued working through the Devon-wide Equality Co-operative, a forum set up to ensure a system-wide oversight of equality issues
- Regular reporting to the Quality Assurance Committee of the CCG (patient and public equality, diversity and inclusion information)
- Regular reporting to the Remuneration Committee of the CCG (workforce equality and diversity information)
- Use of The Equality Delivery System tool to measure CCG performance on equality issues

In line with its agreed equality, diversity and inclusion (EDI) strategy, the CCG publishes a separate report on its progress, which will be available on our website. Consequently, this section provides headline statements in relation to the CCG's performance.

Governance of EDI and system working in Devon

The CCG has established clear lines of reporting between the various groups working on EDI related projects within the CCG and across the system.

The CCG works on EDI for itself and as a key member of the wider Equality Co-operative. This enables the health and care system in Devon to address issues common to all members of the health and social care community. Many members of the co-operative also attend the South West Inclusion Network which enables them to learn from and share with EDI leads beyond Devon.

EDI and the CCG workforce

We undertake work to better understand the diversity of our workforce using the staff survey data. An overview of the staff demography and ethnicity will be found in the CCG's annual Equality, Diversity and Inclusion report. The human resources (HR) team has undertaken a review of the CCG's HR policies and ensured that equality underpins this work.

The Rainbow badge scheme continues at the CCG, supporting a number of staff to be a point of contact and listening ear for people from the LGBT+ community.

The CCG is required to complete a Workforce Race Equality Standard report and a gender pay gap report. These can be found on the CCG website.

Prevention Programme

While the impact of the COVID-19 pandemic on our plans for 2021/22 has been challenging, we have adapted where possible to ensure prevention remained an area of focus within the Devon system.

We continue to target investment from our prevention fund to support both whole-Devon and place-based interventions. 2021/22 has seen us:

- Continue proactive community work to reduce rates of infections within the community setting with our **Community Infection Management Service (CIMS)**. Supporting COVID-19 work in care homes has been a key focus through virtual walk arounds, advice on Personal Protective Equipment (PPE) use, visits, educational sessions and facilitating safe immunisation sessions in homes with outbreaks.

Despite the COVID-19 pressures, the CIMS team have been able to take forward several community-facing projects. These include:

- Scoping the areas supported and creating networks and relationships from scratch
 - Supporting a Devon-wide infection control champions project in care homes
 - Remote COVID-19 education sessions for care home staff
 - The purchase and modification of an infection prevention & control handbook designed for education of care home staff
 - Creating supportive relationships with primary care
 - Trialling IPC audit tool for primary care
 - Supporting with IPC considerations in new builds
 - Investigating community-associated *C. difficile* and *E. coli* cases
 - Input into non-COVID outbreaks, such as flu and norovirus
- Develop new, and expanded existing, **physical activity** schemes in some of our most deprived communities. This has included establishing new walking groups for mid-life and older adults with type-2 diabetes, depression and anxiety, alongside those at risk of frailty, with 60% of new participants reporting themselves as previously “inactive”. We have also adapted to support those at home to stay active during COVID-19 restrictions.
 - Connect approximately 1,000 people living with **obesity** who also have a diagnosis of diabetes, hypertension or both to the 12-week NHS Digital Weight Management Programme, and online behavioural and lifestyle programmes.
 - Provide the first year of two-year’s investment to support our Local Care Partnerships in putting in place interventions that will improve people’s independence, life experience and morbidity through the **prevention of falls**. In turn, this will reduce demands on other parts of the system, such as our urgent community response; urgent and emergency care; and rehabilitation and equipment services.

Investing in **Mental Health** remains a priority for prevention, with suicide prevention an area of particular focus.

- We have adapted our approach to targeting those bereaved by suicide to reflect COVID-19 restrictions, launching an online version of our **suicide bereavement** training offer to staff working with people who lead complex lives. A total of 75 places were made available and were fully booked within 48 hours. Following the positive feedback from these sessions, their success is being built on and some 1750 sessions will be available during 2022-23.
- Training staff have delivered a suite of suicide related courses to staff across our mental health and community services providers.

	Suicide Prevention Training	Post Ligature Physical Healthcare Management	Suicide Response and Safety Planning Training
Devon Partnership NHS Trust (DPT)	90% completion rate (3,053 staff)	37% of eligible clinicians (256 staff)	41% of eligible clinicians (375 staff)
LiveWell South West		Being delivered March – November 2022	Commencing March 2022

DPT is pleased to report that since August 2020 there have been no in-patient suicides and that feedback from staff who have received Post Ligature training is that 100% report an increased confidence in responding to ligature incidents.

- In April 2021 the “Early Intervention Self Harm” service was commissioned as a two year pilot aiming to provide early interventions to support young people aged 11-18 who are self harming. During the first six months 70 young people had been referred to the service, with 54 of these going to receive additional support. Practitioners and school staff have described the service as “reassuring” and that it had had a positive on the happiness of the young people who had received support.

Domestic violence and abuse and **health inequalities** experienced by people with complex needs have been amplified by the pandemic and this trajectory of harm and ‘need’ is likely to continue. Our **Whole Systems for Whole People** work has gathered pace and reach during 2021/22 demonstrating and supporting improvements. We have

- Secured sexual violence Trauma Pathfinder status, comprising nearly £1million of funding over three years to improve pathways and responses to adults experiencing

sexual violence; improve access to professionals trained in the identification of, and response to, complex trauma; encourage the establishment of trauma-informed systems; and build an evidence base to inform new approaches that can be adopted elsewhere

- Started the commissioning of an interpersonal trauma response service for adults and children based upon learning from clinical enquiry and social prescribing pilots
- Produced a range of resources including a GP toolkit and MARAC induction guidance, that are being adopted by other CCGs across the country
- Supported five of our provider trusts to either pilot or core fund independent domestic violence advisors

Our continued investment in social prescribing is to develop the resilience of local communities in meeting the needs of their population.

There are a wide range of programmes identifying with the social prescribing label across the Devon footprint. This work includes link workers, community connectors, wellbeing advisors and community navigators; all of whom connect people to community groups and help the individual develop skills, friendships and resilience to aid their wellbeing.

All 31 Primary Care Networks of GP practices in Devon have appointed at least one social prescriber with a small majority (18) being managed by the voluntary sector. This is particularly prevalent where social prescribing has been established for some time. This is helping to ensure PCN based link workers are well-placed to connect people to resources in their communities as well as learn from the voluntary sector experience via a network of peer support.

Overall, there are now 66 social prescribers operating in the county, with each prescriber having an average caseload of 250 people. Social prescribers have an average of between 6 to 12 contacts with a patient over a three month period. This means that approximately 16,500 people are currently receiving some form of social prescription offer in Devon.

2022/23 will see us retain focus on the prevention of community acquired infections and long term conditions, with specific attention to atrial fibrillation, cardiovascular disease and diabetes. We will support our acute services to provide patients with ready access to **smoking cessation** support and **alcohol care**.

We will work with our four localities to provide support to those at risk of falls and fractures, and those considered frail, within their communities. We will work hand-in-hand with the Devon Health Inequalities programme to ensure our services are meeting the needs of those experiencing health inequalities within Devon. 2021 will see us establish a single, integrated plan for Health Inequalities and Prevention.

This plan will support us to:

- further develop leadership of health inequalities and prevention across Devon
- embed a **strengths-based approach** through which our population will be empowered, with support when needed, to take control of their health and wellbeing to achieve the goals that matter to them
- build on the excellent work of the Plymouth Trauma Network to further spread trauma-informed practice to healthcare
- ensure children, young people, adults and families who have been affected by suicide, whether this be confirmed or suspected, are able to access support

Developing the Population Health Management approach

Population Health Management (PHM) aims to improve the physical and mental health and wellbeing of people, whilst reducing health inequalities within and across a defined population. It requires action to reduce the occurrence of ill-health, including addressing wider determinants of health, and action to slow the progression, in individuals, of existing conditions.

PHM involves a partnership approach across the NHS and other public services including: social services, public health, schools, voluntary sector, housing associations and, importantly, the public. To maximise its impact, all partners work more closely together to improve overall population health. The approach is underpinned by a patient-level population data set and is enabled by data analytics. Taking a data-driven approach to planning drives a more targeted approach to both care design and care management.

In Devon, PHM is enabling the CCG to better understand current, and predict future, health and care demand and commission more integrated and sustainable services thus making better use of public resources. PHM is enabling healthcare providers to identify people who are at risk of ill-health and develop proactive interventions to prevent or delay the onset of long-term conditions and slow the progression of frailty.

The expected outcomes and benefits from implementing PHM in Devon include:

- Increasingly evidence-based decisions that inform the most efficient allocation of resources to prevent illness, improve care and lower costs.
- Financial improvement and improved health outcomes through prevention, early detection and intervention.
- Better monitoring and evaluation of the impact of interventions to improve outcomes or reduce inequalities, and upscaling to maximise benefits.
- Through participation of partners, the opportunity of data linkage across organisations and staff capacity building.

Progress made

To implement Population Health Management successfully and enable our Integrated Care System (ICS) to thrive, Devon system partners have been focusing on the following three areas:

Developing the infrastructure to ensure the basic building blocks of population health management are in place.

- Building the workforce capacity and capability to embed PHM at all levels of our system
- Using PHM tools and techniques to inform the development of new models of care and proactive interventions to improve health outcomes, reduce inequalities and reduce costs.

Our system's involvement in Wave 2 of NHS England's Population Health Management Development Programme has enabled the CCG and our partners to begin developing the technical capabilities and infrastructure needed to deliver PHM. In 2021/22 the national programme enabled local testing and implementation in some PCN sites and in 2022/23 we will be focusing on developing a local programme to support wider spread and adoption.

Key achievements include:

- The delivery of action learning sets to inform strategic thinking and enable progress with PHM at both place and PCN level
- Five PCNs have identified target cohorts and have designed interventions to support their priority groups
- Financial modelling has been undertaken to support the development of the integrated care in Plymouth
- System capability for PHM analytics has been increased through the delivery of action learning sets, huddles and other programme activities
- The Information Governance (IG) arrangements needed to support the wider adoption of PHM have been further developed
- A Devon PHM portal has been developed to enable the sharing of resources and support wider spread and adoption (<http://nwww.devonpublichealthintelligence.nhs.uk/>)

Using PHM to address health inequalities

In Devon the PHM programme will be used as a way to enhance the system's capability in addressing inequalities. The programme has been deliberately designed to involve NHS organisations and local authorities in all localities across the Devon system. Whilst there are currently multiple initiatives across the system, adopting a PHM approach will provide a more consistent framework for tackling inequalities.

Developing enhanced data sharing and analysis will provide intelligence to inform actions that can be taken at each level from direct support to vulnerable individuals, local integrated service provision in the least intensive setting, to system prioritisation and leadership.

The CCG contribution to the delivery of the Joint Health and Wellbeing Strategy

Devon CCG covers three top tier local authorities and associated Health and Wellbeing Boards (HWBs) in Plymouth, Devon and Torbay.

HWBs have identified a vision and key priorities within their Joint Health and Wellbeing Strategies (JHWBS). These strategies have been used to form the basis of the locality care partnership (LCP) plans for each place. Local authority and health organisations along with other stakeholders work closely together to provide leadership for the LCPs.

Plymouth	Devon	Torbay
JHWBS Vision Statements		
<i>To be one of Europe's most vibrant waterfront cities where an outstanding quality of life is enjoyed by everyone.</i>	<i>Health outcomes and health equality in Devon will be amongst the best in the world and will be achieved by Devon's communities, businesses and organisations working in partnership.</i>	<i>To create a healthy Torbay where individuals and communities can thrive</i>
JHWBS Priorities		
Delivering solutions and creating environments which address the wider determinants of health and wellbeing and make healthy choices available.	Create opportunities for all-inclusive economic growth, education and social mobility	Working together, at scale, to promote good health and wellbeing and prevent illness

Reducing health and wellbeing inequalities and the burden of chronic diseases in the city.	Healthy, safe and strong communities creating conditions for good health and wellbeing where we live, work and learn	Enable children to have the best start in life and address the inequalities in their outcomes
Delivering the best health, wellbeing and social outcomes for all people, and reducing and mitigating the impact of poverty, especially child poverty.	Focus on mental health building good emotional health and wellbeing, happiness and resilience	Build emotional resilience in children and young people
Helping ensure that children, young people and adults feel safe and confident in their communities, with all people treated with dignity and respect.	Maintain good health for all supporting people to stay as healthy as possible for as long as possible	Create places where people can live healthy and happy lives
Building strong and safe communities in good quality neighbourhoods with decent homes for all, health-promoting natural and built environments, community facilities and public spaces and accessible local services, alongside supporting restoration		Support those who are at risk of harm and living complex lives, addressing the underlying factors that increase vulnerability

of natural habitats and ecosystems.		
Enabling people of all ages to play an active role in their community and engage with arts and culture and other activities to promote social cohesion and good mental health and wellbeing.		Enable people to age well
Providing a safe, efficient, accessible and health-enabling transport network which supports freedom of movement and active travel and promotes low carbon lifestyles that are beneficial to physical and mental health.		Promote good mental health
Providing vibrant, effective and modern education settings that enable children and young people to develop as active citizens in the community and enjoy a good quality of life in a dynamic and modern economy, and		

delivering quality lifelong learning which is available to everyone and can be tailored to quality employment and social opportunities.		
Ensuring people get the right care from the right people at the right time to improve their health, wellbeing and social outcomes.		
Making Plymouth a centre of clinical excellence and innovation to benefit the sustainability and growth of the medical and health care sectors in the city and to create education and employment opportunities.		

Common areas of priority between the strategies include:

- Common vision around reducing health inequalities and addressing wider determinants of health
- Enabling children to have the best start in life
- Promoting good mental health across the life course
- Creating good education and employment opportunities to improve social mobility
- A focus on living well, encouraging health lifestyles and prevention
- Maintaining independence and good health into older age

Some examples of how the CCG has contributed to the delivery of some of the priorities identified in JHWBS through its commissioning activity this year include:

- Development of an extensive programme to address health inequalities working with partners to address differences in access and outcome by ethnicity, deprivation and other factors
- Continuing to promote annual health checks for people with learning disabilities, autism and/or mental health disorders, to prevent ill health and reduce inequalities
- Improving children and young people's access to school-based mental health support and NHS funded community mental health services
- Encouraging healthy lifestyles by actively developing and commissioning initiatives to support smoking cessation, improve alcohol care and prevent diabetes

Shared Aspirations

Devon's NHS organisations, together with Devon County, Plymouth City and Torbay Councils, and Livewell Southwest have a single vision and shared aspirations for health and care in Devon over next ten years.

Vision agreed by all partners:

"Equal chances for everyone in Devon to lead long, happy and healthy lives"

Work is currently being undertaken to develop a single 'Devon Plan' which will be a description of the actions we will collectively take to address the challenges that health and care services in Devon face and deliver our vision. The 'Devon Plan' will encompass our system's Long Term Plan which was developed in 2019 to respond to national and local priorities including those identified within Joint Health and Wellbeing Strategies (JHWBS)

At its core the Devon Plan has six ambitions, with an aim to shape services around the needs and preferences of the Devon population, while improving outcomes, tackling health inequalities unwarranted variation, being financially sustainable and a great place to work.

The common areas of priority within the Joint Health and Wellbeing Strategies are reflected within our ambitions and to close working and full participation of CCG representatives in local HWBs.

The Devon Plan ambitions include:

Ambition 1: Effective and efficient care

- Collaborate across the system to address safety, effectiveness, experience and productivity.
- Health and care organisations will work together to provide the best possible services. They will use Devon taxpayer's money to deliver value for the population by reducing waste, tackling unwarranted clinical variation and improving productivity everywhere.

Ambition 2: Integrated Care Model

- Systematic delivery of the integrated care model across Devon.
- There will be a shift to out of hospital care through enhanced Primary Care Networks, community (including mental health), social care and voluntary & community services.

This will reduce the growth in acute urgent care, improve access to primary care and enable more people to be cared for at home.

Ambition 3: People Led Change

- A citizens-led approach to health and care.
- A new approach will be adopted to reduce variations in outcomes, gaps in life expectancy and health inequalities across Devon. There will be a shared way of working with people and communities to identify priorities and tackle the root causes of problems such as substance misuse, domestic abuse and sexual violence, homelessness and mental ill-health. Information and intelligence across services will be used to target resources in the most effective way.

Ambition 4: Children and young people

- Invest in children and young people: to have the best start in life, be ready for school, be physically and emotionally well and develop resilience throughout childhood and on into adulthood.
- All children and young people in Devon will have the best start in life, grow up in loving and supportive families, and be happy, healthy and safe. Children, young people, their families and carers and communities will have access to a personalised, sustainable and coordinated system of care and support which meets needs early and improves their quality of life so that they can live well throughout life and make the most of the choices and opportunities available to them.

Ambition 5: Digital Devon

- Invest in a digital Devon: only tell your story once, first contact will be digital, self-care, digital connectivity
- Digital advances are continually creating possibilities for preventing ill health and improving care and treatment and modernising the way we work. Adopting a 'digital first' approach across the whole system will deliver transformational benefits of developments in technology, robotics, artificial intelligence, wearables, analytics changing experiences of and access to care for individuals; enabling efficiencies for staff; and allowing advances in quality and safety; and improving productivity.

Ambition 6: Equally well in Devon

- Work together to tackle the physical health inequalities for people with mental illness, learning disabilities and/or autism.
- The physical health of some people with mental illness, learning disabilities, and/or autism is significantly worse than the health of Devon's population as a whole. Health and care providers, commissioners, professional bodies, service user and carer organisations, and charities in Devon are committed to working together to bring about equal physical health for all.

Financial review

The CCG planned and produced a 2021/22 year end surplus of £5.28m, meaning that its income was greater than the expenditure incurred.

The CCG worked within a financial framework that was put in place to meet the challenges of the COVID pandemic. The CCG received a fixed funding envelope to cover the Devon Integrated Care System (ICS), including a CCG primary medical care funding and funding for COVID related costs.

The CCG worked in conjunction with partner NHS organisations (listed below) to agree the distribution of the ICS's fixed funding allocation. Each of the partners received an allocation for normal business, as well as an allocation for COVID related expenditure:

- NHS Devon CCG
- University Hospitals Plymouth NHS Trust
- Royal Devon and Exeter NHS Foundation Trust
- Northern Devon Healthcare NHS Trust
- Torbay and South Devon NHS Foundation Trust
- Devon Partnership NHS Trust

Whilst systems were expected to breakeven in aggregate, organisations within them were permitted by mutual agreement across their system to deliver surplus and deficit positions. Devon CCG's reported position in 2021/22 against its revenue resource limit is set out below:

Financial Summary	2021/22 £ million
Revenue resource limit	2,564.54
Total net operating cost for the financial year	2,559.26
(Overspend) / Underspend	5.28

The CCG had purchased capital items totalling £0.39m in 2021/22, in line with its capital resource limit.

The CCG also managed to meet its other financial duties, including:

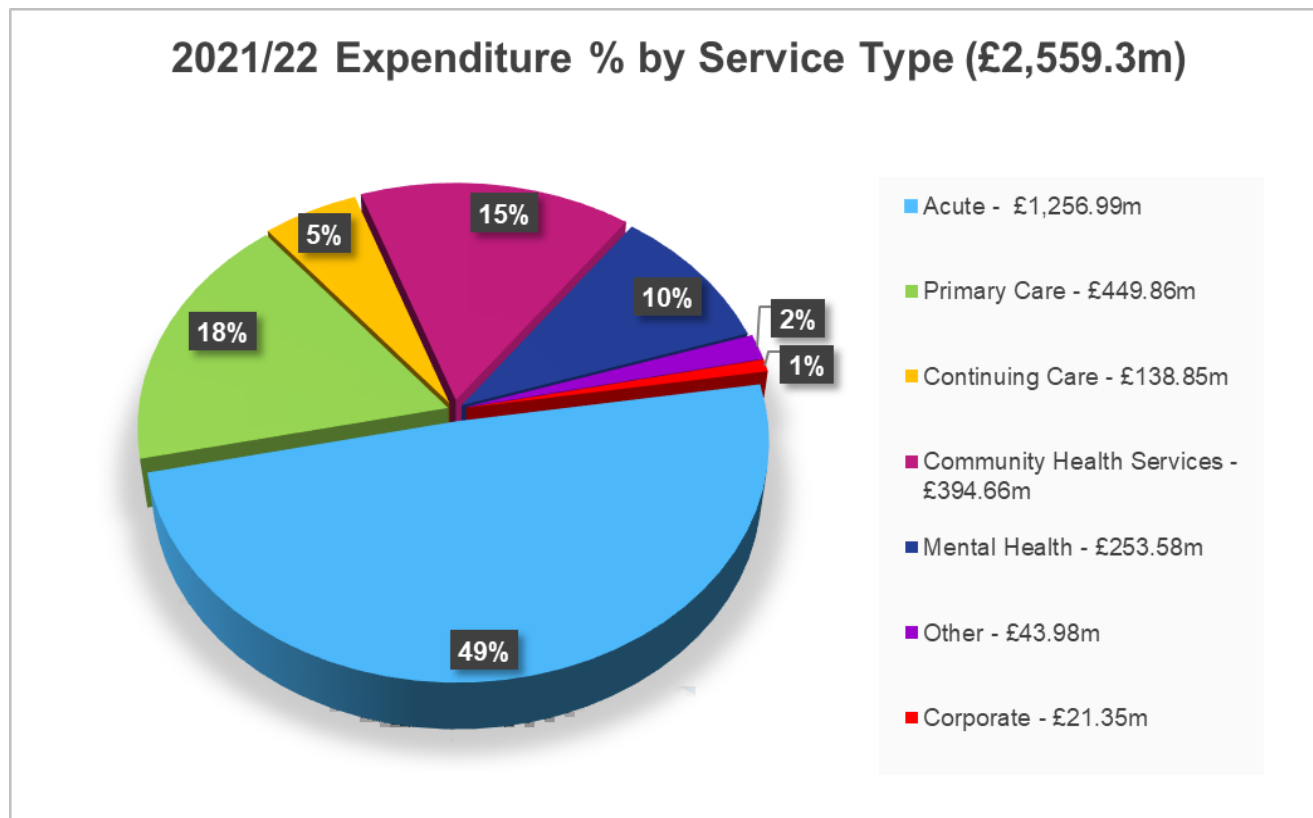
- Running costs contained within the agreed allocation –for the CCG this was achieved with reported expenditure of £21.34 million against £23.72 million funding allocated.
- Managing cash resources received from NHS England against a mandated threshold, the annual cash drawdown requirement.

- Comply with the Prompt Payment Code.
- Meeting the mental health investment standard which requires the CCG to increase investment in mental health in line with the overall increase in the CCG financial allocation. For 2021/22, the target investment in mental health was £243.93m and the CCG achieved £245.22m.

How the CCG funds were spent in 2021/22

The CCG is responsible to its members and the public in relation to how it allocates and spends taxpayers' money in each financial year.

In 2021/22 the CCG budget spend was allocated in the following proportions, which largely reflects historical levels of expenditure, trend in current demand but also the impact of the pandemic. The following pie chart shows the annual expenditure by service type which includes contract and non-contractual expenditure with NHS providers, independent providers, local authorities and the voluntary sector, and shows the running costs for the CCG:



Within the above expenditure the CCG spent £31.5m on COVID-19 related costs. The majority of which was spend on Community Health Services and Primary Care.

Explanation of going-concern basis

The Governing Body is required to assess, at the time of preparing the financial statements, whether the entity is a going concern. In other words, will the entity continue to operate for the foreseeable future?

Indicators of an uncertain future would include the failure to achieve one or more statutory financial duties – for example, the breach of the resource limit, or operating with negative cash flows.

2021/22 resulted in a £5.28m surplus for Devon CCG. To ensure that health services continue to meet the needs of the population and to support the achievement of national performance targets, the 2022/23 CCG plans indicate that it will be a very challenging year.

The 2022/23 plan will have an impact on the cash flow of the CCG. However, overall cash is managed at an NHS England level. Therefore, if the total cash used by NHS England does not breach its cash limit, set by Treasury and the Department of Health, NHS England will have the flexibility to provide cash support to CCGs when needed.

In line with the NHS Long Term Plan the Integrated Care System for Devon was launched 1 April 2021. Integrated care systems are new partnerships between the organisations that meet health and care needs across an area, to coordinate services and to plan in a way that improves population health and reduces inequalities between different groups. As signalled in the UK Government's white paper, Integration and Innovation: working together to improve health and social care for all, it is expected that the commissioning functions of the CCG will be undertaken by the newly formed statutory body from 1 July 2022.

The Secretary of State has directed that, where Parliamentary funding continues to be voted to permit the relevant services to be carried out elsewhere in the public sector, this is normally sufficient evidence of going concern.

With the above in mind, the Governing Body of Devon CCG has prepared these financial statements on a going concern basis. This is effectively in relation to its intention to continue its operations for the foreseeable future and the awareness of any circumstances affecting this in its preparation of these financial statements.

Name of external auditor, plus costs

The CCG uses the services of Grant Thornton UK LLP as its external auditor and paid £73,246 (£87,895 including VAT) for the 2021/22 audit. In 2021/22 there is an additional payment of £8,500 (£10,200 including VAT) for 2020/21's audit fee that wasn't accounted for in the 2020/21 accounts. The resultant 2020/21 audit fee was £83,500 (£100,200 including VAT).

Included in the accounts is £10,000 (£12,000 including VAT) for an independent review of the 2021-22 Mental Health Investment Standard.

Prompt Payment Code

The CCG has signed up to the Government-led initiative called The Prompt Payment Code, through which approved signatories undertake to:

- Pay suppliers on time
- Give clear guidance to suppliers
- Encourage good practice

The initiative helps to increase supplier confidence that invoices will be paid within clearly defined terms and demonstrate the commitment to support local and small businesses as a result. More information on the Prompt Payment Code can be viewed on the following website: <https://www.smallbusinesscommissioner.gov.uk/PPC> .

Basis of accounting

The financial statements contained within this report have been prepared in accordance with the direction given by NHS England under the National Health Service Act 2006 (as amended) and in a format instructed by the Department of Health with the approval of HM Treasury.

The accounts present our results for, and financial position to, the year ended 31 March 2022. They have been prepared under International Financial Reporting Standards (IFRS) using the accounting policies shown in the notes to the accounts, in accordance with the 2021/22 Group Accounting Manual (GAM) issued by the Department of Health and Social Care. They comprise a Statement of Financial Position, Statement of Comprehensive Net Expenditure, a Statement of Cash Flows, and a Statement of Changes in Taxpayers' Equity, all with related notes.

Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments, and special notation in the accounts to draw them to the attention of Parliament. They are divided into different categories including cash losses, bad debts, extracontractual payments and compensation.

During 2021/22 there were three ex-gratia payments totalling £8,360.80.

2022/23 Financial Outlook

The NHS confirmed that the financial arrangements for 2022/23 will continue to support a system-based approach to planning and delivery. The plans are based on the outcome of capacity and service planning reviews, together with the prioritisation of investments and disinvestments in accordance with the NHS Long Term Plan, the strategic plan for Devon CCG, as well as the wider Devon ICS plans.

The priorities that Devon ICS, incorporating Devon CCG, will focus on and the improvements the population will see, in line with national requirements, are as follows:

Priorities

- Integrate care
- Improve health outcomes
- Tackle inequalities
- Enhance productivity
- Support social and economic development

Improvements we will see

- Safer and higher quality of services
- Greater focus on your wellbeing
- Reductions in variation of access and outcomes
- Developing you and our people
- Improved efficiency and value for money by sharing of resources

Although we do not know what the pattern of COVID-19 transmission will look like over the next 12 months, Devon CCG has considered the impact COVID-19 has had on our population and services while shaping the 2022/23 operational plan.

2022/23 will be a very challenging year as the ICS works to continue the recovery through COVID-19. Reducing the waiting times, maximising recovery opportunities, driving system efficiency and reinvesting in less expensive, more innovative and effective integrated care models.

Managing our financial risks

The financial position of the CCG needs to be assured through the continued development of safe and deliverable savings programmes across the health community.

The Devon ICS is committed to working collaboratively. The 2022/23 CCG plan carries a level of risk, some of which has been contained with partners organisations, through the approach to financial principles and collaborative working but importantly the translation of the financial framework set as part of national planning assumptions.

The plan is dependent on the on-going evaluation and mitigation of a number of broad financial risks through 2022/23:

- Although the ‘Living with Covid’ plan is in effect, the arrangements for returning to business-as-usual presents both challenge and opportunity from a financial management perspective. We must ensure the system receives adequate resources to cover the additional costs incurred, due to the crisis, in line with the additional resource commitments for the NHS made by the Government, for example the Elective Recovery Fund. We will fully assess changes to the cost of commissioned services, both positive and negative, because of the adjustments to service delivery models required through the pandemic that can and should be retained for the foreseeable future.

- Funding provider contracts and commitments into 2022/23 and managing in-year financial risk. This will be particularly challenging given the level of system savings required.
- Managing within the running costs allowance which has been capped for a number of years. There is a risk of unforeseen staffing pressures due to workforce requirements of the ICB and system working.

The CCG must also play an active role in the mitigation of risk to the overall system position, supporting providers in the delivery of their challenging cost reduction plans through delivering a level of demand management which will support a step change and support a transformational approach to the capacity within the provider sector.

The CCG will only achieve its objectives through effective collaboration with its partners. It continues to work closely with local authorities, primary care services and local hospitals to improve the outcomes and experience of patients. The organisation seeks the involvement of service-users and members of the public to enhance its understanding of the health needs and experience of the local population.

In addition to those outlined above, there are other risks because of the environment the CCG operates in, with NHS funding principally voted by Parliament. As such, it is reliant on the elected government for its income largely dependent on priorities at the time of voting.

It is not possible for the CCG to mitigate all the risks it faces. Risk is managed within the organisation using a risk register. Risks are scored against the likelihood of occurrence, the potential impact, and the strength of the risk controls in place. Responsibility for managing each risk is assigned to an appropriate individual. The risk register is reviewed periodically by the Audit Committee, the Senior Leadership Team and the Governing Body to ensure that appropriate controls are in place.



Jane Milligan

Accountable Officer

NHS Devon Clinical Commissioning Group

27 April 2022

Accountability report

This section includes information on how we ensure that our organisation runs safely and effectively and that we make the best use of the resources available to us. It includes

- A Corporate Governance Report which explains how our governance structures operate and how they support the achievement of the CCG's objectives
- A Remuneration and Staff Report which gives information about our staff and how they are paid
- A Parliamentary Accountability and Audit Report which some organisations are required to produce to give disclosures on statutory requirements.

Corporate governance report

Members' report

CCGs are clinically-led membership organisations made up of general practice. The members of the CCG are responsible for determining the governing arrangements for the CCG, including arrangements for clinical leadership which are set out in the CCG's constitution. NHS Devon CCG comprises 121 member practices across our identified localities, all grouped into primary care networks. Each primary care network has a clinical director. Each of our four localities (North, South, East and West) also selects a Locality Clinical Representative who is a member of the Governing Body.

**Note: Mewstone and Beacon PCNs are within the Plymouth locality, but also have a footprint within the West locality.*

East locality	
Primary Care Network	Practice name
Nexus	Mount Pleasant
	Heavitree
	South Lawn
	ISCA

	Hill Barton
TASC	Axminster Medical Practice
	Seaton & Colyton Medical Practice
	Townsend House Medical Centre
Outer Exeter	Cranbrook Medical Centre
	Ide Lane Surgery
	Pinhoe & Broadclyst Medical Practice
	Topsham Surgery & Glasshouse Medical Centre
	Westbank Practice
Honiton/Ottery/ Sid Valley (HOSMS)	Honiton Surgery
	Coleridge Medical Centre
	Sid Valley Practice
Exeter West	Foxhayes Practice
	St Thomas Medical Group

Exeter City	Barnfield Hill Surgery
	Clocktower Surgery
	Southernhay House Surgery
	St Leonards Practice
	Whipton Surgery
	Wonford Green Surgery
WEB	Claremont Medical Practice
	Rolle Medical Partnership
	Imperial Surgery
	Haldon House Surgery
	Woodbury Surgery
	Budleigh Salterton Medical Practice
	Raleigh Surgery
Culm Valley	Bramblehaies Surgery
	Blackdown Practice
	College Surgery
	Sampford Peverell Surgery

	Wyndham House Surgery
Tiverton	Amicus Health
	Castle Place
Mid Devon Healthcare	Bow Medical Practice
	Cheriton Bishop & Teign Valley Practice
	Mid Devon Medical Practice
	Redlands Primary Care
	Wallingbrook Health Group
North Dartmoor	Chagford Health Centre
	Blake House Surgery (Black Torrington)
	Moretonhampstead Health Centre
	Okehampton Medical Centre

North locality	
Network	Practice name

Torridge	Bideford Medical Centre
	Castle Gardens Surgery
	Hartland Surgery
	Northam Surgery
	Wooda Surgery
	Torrington Health Centre
Barnstaple Alliance	Brannams Medical Centre
	Fremington Medical Centre
	Litchdon Medical Centre
	Queens Medical Centre
Coast & Country	Ruby Country Medical Group
	Bradworthy Surgery
North Devon Coastal	Caen Medical Centre
	South Molton Medical Centre
	Lynton Health Centre
	Combe Coastal

West locality	
Network	Practice name
West Devon	Abbey Surgery
	Tavyside Health Centre
	Yelverton Surgery
Beacon Medical Group *	<i>Beacon Medical Group</i>
Mewstone *	<i>Wembury Surgery</i>
	<i>Dean Cross Surgery</i>
	<i>Church View Surgery</i>
	<i>Yealm Medical Centre</i>

Plymouth	
Network	Practice name

Beacon Medical Group*	Beacon Medical Group
Drake Medical Alliance Limited	North Road West MC
	Roborough Surgery
	Knowle House Surgery
	Wycliffe Surgery
	Lisson Grove and Woolwell Medical Centre
Mayflower	Mayflower Medical Group
Waterside Health Network	Devonport Health Centre
	St Levan Surgery
	Adelaide Surgery
	West Hoe Surgery
	Stoke Surgery
	Peverell Park Surgery & University Medical Centre
	St Neots Surgery

Mewstone*	Wembury Surgery
	Dean Cross Surgery
	Church View Surgery
	Yealm Medical Centre
Sound	Budshead Medical Practice
	Elm Surgery
	Friary House Surgery
	Oakside Surgery
	Southway Surgery
Pathfields Medical Group	Pathfields
	Beaumont Villa Surgery

South locality	
Network	Practice name
Baywide	Compass House Medical Centres
	Pembroke House Surgery

	Chilcote Surgery
Torquay	Southover Medical Practice
	Brunel Medical Practice
	Chelston Hall Surgery
	Croft Hall Medical Practice
Newton West	Albany Surgery Newton Abbot
	Bovey Tracey & Chudleigh Medical Practice
	Kingskerswell & Ipplepen Medical Practice
South Dartmoor and Totnes	Ashburton Surgery
	Buckfastleigh Medical Centre
	Catherine House Surgery
	Leatside Surgery
	South Brent Health Centre
Paignton & Brixham	Mayfield Medical Centre
	Corner Place Surgery

	Old Farm Surgery
The Coastal Network	Channel View Medical Practice
	Teign Estuary Medical Group
	Dawlish Medical Group (known as Barton Surgery)
Templer Care Network	Buckland Surgery
	Cricketfield Surgery
	Devon Square Surgery
	Kingsteignton Medical Practice
South Hams	Dartmouth Medical Practice
	Modbury Health Centre
	Chillington Health Centre
	Redfern Health Centre
	Norton Brook Medical Centre

Our Governing Body

The Governing Body ensures that the CCG operates effectively and efficiently, with good governance. The Governing Body, in line with the CCG constitution, currently has 19 voting members, of which 12 are men and 7 are women. Our lay members have a clear statutory role in acting as an independent and expert voice on the board.



Dr Paul Johnson^r

Clinical chair



Jane Milligan

Chief Executive



Nick Ball^{r}**

Vice chair; Non-executive lay member,

Governance and probity



Simon Tapley

Deputy accountable officer



Dr Simon Kerr^{}**

Clinical representative, eastern locality



Dr Shelagh McCormick^r

Clinical representative, western locality



Dr David Greenwell

Clinical representative, southern locality

(Job share with Dr Matthew Fox who does not attend the board meetings)



Dr John Womersley^{}**

Clinical representative, northern locality



Darryn Allcorn**

Chief Nurse



Andrew Millward

Director of
Communications, HR,
Governance and IT



John Dowell**

Chief Finance Officer



Jo Turl

Director of
commissioning – out
of hospital



John Finn

Director of
commissioning – in
hospital



Dr Nick Kennedyr**

Non-executive lay
Member - Secondary
care doctor



Gaynor Appleby^r

Non-executive lay
member,

Allied healthcare



Graham Turnerr**

Non-executive lay
member,

finance and
remuneration



Judy Hargadonr**

Non-executive lay
member,

primary care and
prevention



Glynis Atherton^r

Non-executive lay member, quality assurance



Charlotte Burrows^r

Non-executive lay member, patient and public involvement

Until 30.11.21

Alison Davis*



Associate non-executive lay member (01.04.21 – 01.12.21)

Non-executive Director (01.12.21 – 31.03.22),

Independent social worker



James Wooldridge*

Associate non-executive lay member, Recovery Devon/mental health

Until 11.10.21

*non-voting member

**member of Audit Committee

^r member of Remuneration Committee

The above represents the membership of the Governing Body during the reporting year and as of 31 March 2022.

The CCG Governing Body has regularly invited the following individuals to attend any or all of its meetings as attendees who are non-voting:

Local authority representatives, specifically Public Health in accordance with Section 14W of the NHS Act. Within the CCG local geography, this representation would be from Devon County Council, Plymouth City Council and Torbay Council as described in section 2.2 of the CCG's constitution.

Biographies for our Governing Body members are available on our website:

<https://devonccg.nhs.uk/about-us/governing-body-and-committees/governing-body-members>

The Governing Body follows the Nolan principles of 'standards of board behaviour' in all that it does, and has a declaration of interests register, which is scrupulously maintained and shared openly. Governing Body meetings are held in public and the CCG endeavours to manage the majority of its clinical commissioning decision-making in public. From the start, the Governing Body has put the patient at the centre of its decision making. Its meetings begin with a patient story, usually presented by one of our clinical members, and at the end of most meetings members reflect on the difference their decision making might have made to that patient.

Governing Body disclosures

The declaration of interests register includes all interests declared by Governing Body members, employees and members of committees or subcommittees (including committees and subcommittees of the Governing Body). It is published on our website:

<https://www.newdevonccg.nhs.uk/about-us/governing-body-102039>

In accordance with the CCG's constitution and section 140 of The National Health Service Act 2006, the CCG's accountable officer must be informed of any interest which may lead to a conflict with the interests of the CCG and the public in relation to a decision to be made by the CCG, and that needs to be included in the Register within 28 days of the individual becoming aware of the potential for a conflict. If required, the register is updated regularly (at no more than three-monthly intervals).

Interests that must be declared (whether such interests are those of the individual themselves or of a family member, close friend or other acquaintance of the individual) include:

- Roles and responsibilities held within member practices
- Directorships, including non-executive directorships, held in private companies or PLCs
- Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the CCG
- Shareholdings (more than five percent) of companies in the field of health and social care
- A position of authority in an organisation (eg, charity or voluntary organisation) in the field of health and social care
- Any connection with a voluntary or other organisation contracting for NHS services
- Research funding/grants that may be received by the individual or any organisation in which they have an interest or role

Any other role or relationship which the public could perceive would impair or otherwise influence the individual's judgement or actions in their role within the CCG.

Personal data related incidents

During the year, the CCG recorded 123 minor internal incidents with no or low risk. There was therefore no reporting to the Information Commissioner's Office.

Statement of disclosure to auditors

Each individual who is a member of the CCG at the time the Members' Report is approved confirms:

- So far as the member is aware, there is no relevant audit information of which the CCG's auditor is unaware that would be relevant for the purposes of their audit report
- The member has taken all the steps that they ought to have taken in order to make him or herself aware of any relevant audit information and to establish that the CCG's auditor is aware of it.

Modern Slavery Act

Devon CCG fully supports the Government's objectives to eradicate modern slavery and human trafficking but does not meet the requirements for producing an annual Slavery and Human Trafficking Statement as set out in the Modern Slavery Act 2015. It is committed to ensuring that there is no use of modern slavery in its supply chain, and work on this will be redoubled once resources allow CCG personnel to return to their substantive posts from their redeployment into the COVID-19 response.

Statement of accountable officer's responsibilities

The National Health Service Act 2006 (as amended) states that each Clinical Commissioning Group shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board (NHS England). NHS England appointed Jane Milligan to be the Accountable Officer of NHS Devon CCG. The responsibilities of an Accountable Officer are set out under the National Health Service Act 2006 (as amended), Managing Public Money and in the Clinical Commissioning Group Accountable Officer Appointment Letter. They include responsibilities for:

- The propriety and regularity of the public finances for which the Accountable Officer is answerable
- For keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Clinical Commissioning Group and enable them to ensure that the accounts comply with the requirements of the Accounts Direction)
- For safeguarding the Clinical Commissioning Group's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities)
- The relevant responsibilities of accounting officers under Managing Public Money
- Ensuring the CCG exercises its functions effectively, efficiently and economically (in accordance with Section 14Q of the National Health Service Act 2006 (as amended)) and with a view to securing continuous improvement in the quality of services (in accordance with Section 14R of the National Health Service Act 2006 (as amended))

- Ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the National Health Service Act 2006 (as amended)

Under the National Health Service Act 2006 (as amended), NHS England has directed each Clinical Commissioning Group to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Clinical Commissioning Group and of its net expenditure, Statement of Financial Position and cash flows for the financial year.

In preparing the accounts, the Accountable Officer is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- Make judgments and estimates on a reasonable basis
- State whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the financial statements
- Prepare the financial statements on a going concern basis
- Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgments required for determining that it is fair, balanced and understandable

I also confirm that:

- As far as I am aware, there is no relevant audit information of which the CCG's auditors are unaware, and that as Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the CCG's auditors are aware of that information.



Jane Milligan

Accountable Officer

NHS Devon Clinical Commissioning Group

16 June 2022

Annual governance statement

Introduction and context

NHS Devon Clinical Commissioning Group is a body corporate established by NHS England on 1 April 2019 under the National Health Service Act 2006 (as amended).

The clinical commissioning group's statutory functions are set out under the National Health Service Act 2006 (as amended). The CCG's general function is arranging the provision of services for persons for the purposes of the health service in England. The CCG is, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its local population.

As at 1 April 2022, the clinical commissioning group is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the clinical commissioning group's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and in my Clinical Commissioning Group Accountable Officer Appointment Letter.

I am responsible for ensuring that the clinical commissioning group is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within the clinical commissioning group as set out in this governance statement.

Governance arrangements and effectiveness

The main function of the governing body is to ensure that the group has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically and complies with such generally accepted principles of good governance as are relevant to it.

The CCG's membership comprises 121 member practices, working together within 31 primary care networks across Devon. A full list of member practices is included in the Members' Report at page 71.

The membership and attendance record for the Governing Body and its committees are detailed at appendix 1. The Governing Body met nine times in public during 2021/22.

The Governing Body has six committees reporting to it. This includes three statutory committees of the Governing Body, as outlined in the constitution, and an additional three committees, namely Quality Assurance Committee, Finance and Performance Committee and Commissioning Committee.

The Governing Body committees have each undertaken an annual effectiveness review during 2021/2022. This review was focused on what good practice could be transitioned into the Integrated Care Board and details presented at the shadow committees and Governing Body during quarter 1.

Audit Committee – Statutory Requirement	
Chair	Chair Nick Ball, Non-Executive Director/Lay Member, Conflict of Interests Guardian
Terms of Reference	Approved July 2021
Purpose	The purpose of the Audit Committee is to assist the CCG in delivering its responsibilities for the conduct of public business, and the stewardship of funds under its control. In particular, the Committee will seek to provide evidence-based assurance to the Governing Body that an appropriate system of internal control is in place to ensure that: • Business is conducted in accordance with the law and proper standards • Public money is safeguarded and properly accounted for • Financial statements are prepared in a timely fashion, and give a true and fair view of the financial position of the CCG for the period in question • Affairs are managed to secure economic, efficient and effective use of resources • Reasonable steps are taken to prevent and detect fraud lead by the Chief Finance Officer and other irregularities Governing bodies can – if they choose – nominate a ‘subset’ of the Audit Committee to act as the Auditor Panel. If a subset is used, there must be at least three Members with a majority who are independent and non-executive Members of the Governing Body. (HFMA briefing December 2015)

Remuneration and Strategic Workforce Committee – Statutory Requirement	
Chair	Chair Graham Turner, Non-Executive Director/Lay Member, Chair Finance and Performance Committee
Terms of Reference	Approved July 2021
Purpose	The purposes of the Remuneration and Strategic Workforce Committee are to: Part 1 - Make recommendations to the governing body on determinations about pay and remuneration for Very Senior Manager (VSM) employees of the clinical commissioning group and people who provide services to the clinical commissioning group and allowances under any pension scheme it might establish as an alternative to the NHS pension scheme. Part 2 - Provide assurance and oversight of strategic people management and organisational development identifying key issues and risks requiring discussion or decision by the Governing Body The Remuneration and Strategic Workforce Committee has clear delegations for decision making which are set out in the Scheme of Reservation and Delegation.

Primary Care Commissioning Committee – Statutory requirement	
Chair	Judy Hargadon, Non- Executive Director/Lay Member, Chair Primary Care Commissioning Committee
Terms of Reference	Approved March 2021
Purpose	The Committee has been established in accordance with the above statutory provisions to enable the members to make decisions on the review, planning and procurement of primary care services in Devon, under delegated authority from NHS England. In performing its role, the Committee will exercise its management of the functions in accordance with the agreement entered into between NHS

England and NHS Devon CCG, which will sit alongside the delegation and terms of reference.

The role of the Committee shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act.

The specific obligations of the CCG with respect to the delegated functions are set out in section 6 and schedule 2 of the Delegation Agreement and include:

Decisions in relation to the commissioning, procurement and management of GMS, PMS and APMS contracts including:

- a) the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing breach / remedial notices, and removing a contract);
- b) Newly designed enhanced services (“Local Enhanced Services” and “Directed Enhanced Services”);
- c) Local incentive schemes as an alternative to the national Quality Outcomes Framework (QOF) (including the design of such schemes);
- d) ‘Discretionary’ payments (e.g., returner/retainer schemes);
- e) Commissioning urgent care for out of area registered patients.

Planning the primary medical services provider landscape in Devon, including considering and taking decisions in relation to:

- a) The establishment of new GP practices (including branch surgeries) in the area, and the closure of GP Practices.
- b) Approving practice mergers.
- c) Managing GP practices providing inadequate standards of patient care, ensuring patients receive appropriate care.
- d) The procurement of new Primary Medical Services Contracts.
- e) Dispersing the lists of GP practices.
- f) Agreeing variations to the boundaries of GP practices; and
- g) Co-ordinating and carrying out the process of list cleansing in relation to GP practices.

Decisions in relation to the management of poorly performing GP Practices including, without limitation, decisions and liaison with the CQC where the CQC has reported non-compliance with standards (but excluding any decisions in relation to the performers list).

Decisions in relation to the Premises Costs Directions Functions.

The CCG will also carry out the following activities:

- To plan, including needs assessment, primary care services in Devon.
- To undertake reviews of primary care services in Devon.
- To co-ordinate a common approach to the commissioning of primary care services generally.
- To manage the budget for commissioning of primary care services in Devon.

The Primary Care Operational Group will review operational contractual issues impacting on primary care delivery working within approved frameworks and decision-making authority from the Primary Care Commissioning Committee. This includes operational decisions pertaining to the Devon CCG primary medical care commissioning budget and making strategic recommendations to PCCC.

The Primary Care Commissioning Committee is accountable for the management of the Devon CCG primary medical care commissioning budget. A finance report on the financial position of the budget will be submitted to PCCC monthly to inform strategic decision making

Finance and Performance Committee	
Chair	Graham Turner, Non-Executive Director/Lay Member, Chair Finance and Performance Committee
Terms of Reference	January 2021
Purpose	The Finance and Performance Committee is the overarching finance assurance committee. To provide assurance that the commissioning of services is; evidence based, in line with the strategic objectives of the CCG, and inclusive of national and local requirements. Oversee CCG performance against statutory duties and legislation for financial governance, escalating any issues considered to impact on the commissioning of services. To provide assurance to the Governing Body and Audit Committee that the CCG is achieving the commissioning, financial and performance elements of its plan. This is to be achieved through judgement, scrutiny, and independent and objective review. To have oversight of budget, financial plans and any financial recovery plans. Review and approve finance and performance reports prior to submission to the Governing Body. To objectively assess and assure the Governing Body that the internal business support services are operating effectively, are responsive to the business need and offer value for money. Oversee care pathways and services that support the financial plans and vision of the CCG. Consider clinical quality and safety in all commissioned services and make recommendations to the Quality and Assurance Committee or Governing Body as appropriate. Ensure a clear escalation process, including appropriate trigger points, is in place to enable the committee to respond when the CCG is under financial pressure. The committee will meet jointly with the Quality Assurance Committee on a regular basis, as determined in the corporate calendar, to ensure that

	there are robust and functioning systems in place to commission safe, economical and effective treatment and care for patients, and that the experiences of patients are cost effective and positive.
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Quality Assurance Committee	
Chair	Glynis Atherton, Non-Executive Director/Lay Member, Chair Quality Assurance Committee
Terms of Reference	Approved February 2021
Purpose	To quality assure, in an oversight role, the delivery of quality standards within commissioned services and to influence prioritisation of those services commissioned within the context of Devon's strategic plan and NHS long term plan. The Quality Assurance Committee will oversee performance against constitutional standards and statutory duties as well as legislation for clinical governance and escalate to the Governing Body, through the Committee Chair, any issues of concern considered to impact on the commissioning of high quality, safe care. It is the responsibility of the committee to make recommendations to the Governing Body of the CCG on determinations about the assurances received surrounding quality issues for the CCG.

Commissioning Committee	
Chair	Dr Claire Hooper, Strategic Clinical Advisor (Planned Care)
Terms of Reference	Approved February 2021
Purpose	The purpose of the Committee is to - • Ensure the CCG fulfils the functions, duties and responsibilities as set out in the CCG's Constitution in relation to its commissioning function • Co-ordinate operational aspects of the organisation to ensure that the CCG meets its strategic and operational objectives • Ensure that there is clinical input to commissioning decisions.

UK Corporate Governance Code

NHS Bodies are not required to comply with the UK Code of Corporate Governance.

We report our corporate governance arrangements by drawing on best practice available, including those aspects of the UK Corporate Governance Code we consider to be relevant to the CCG and best practice. This governance statement is therefore intended to demonstrate the CCG's compliance with the principles set out in the Code.

Discharge of Statutory Functions

In light of the recommendations of the 1983 Harris Review, the CCG has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislature and regulations. As a result, I can confirm that the CCG is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions. Responsibility for each duty and power is clearly outlined in the CCG's scheme of reservation and delegation, within the financial limits policy delegations are allocated to a lead director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the CCG's statutory duties. The financial risks in relation to financial sustainability are clearly visible on the assurance framework and corporate risk register. Controls and assurances are reviewed and updated at each monthly Finance and Performance Committee and reported through to the Governing Body no less than four times a year

Risk management arrangements and effectiveness

The CCG is committed to a strategy that minimises risks to the organisation, staff and patients and stakeholders through a comprehensive system of internal controls, while providing maximum potential for flexibility, innovation and best practice in delivery of its strategic objectives. The CCG works to all applicable legislation and NHS guidance, and where risk forms a part of the CCG's work, this is assessed and recorded on the risk register.

The CCG has a comprehensive approach to risk management which has been assessed by internal audit as significant. The CCG maintains a risk register for all identified risks which are linked to the relevant element of the CCG's Corporate Objectives. A 5 x 5 risk scoring matrix is consistently applied to all risks, and the impact and likelihood of all risks are regularly assessed. This ensures that risks across different functions (e.g. finance, patient safety, data security) are objectively rated and compared on a single register.

All risks recorded on the register are assigned to one of the CCG's directors, a risk owner who is a senior officer within the CCG and are supported by a directorate risk coordinator. A risk assurance checklist is used to ensure that all identified risks are consistently scored in terms of likelihood and impact, and that the controls, assurances, and action plans are recorded. All risks are reviewed at least quarterly, and the length of time a risk has remained at its current risk score is reported. The CCG corporate risk register is reviewed by each of the CCG's committees, either in full or as relevant to the remit of that committee.

The Board Assurance Framework (BAF) has been refreshed to reflect the revised corporate objectives which covered December 2020 to March 2022, and this has been reported to Audit Committee and Governing Body and further embedded throughout the CCG.

The Governing Body has discussed and agreed the CCG's risk appetite. The CCG will ensure high quality, with very limited tolerance of risk regarding patient and public safety. The CCG is eager to be innovative and to choose options offering potentially higher business rewards regarding finance, capacity and capability risks. The CCG is willing to consider all potential delivery options regarding patient and public safety risks.

The CCG uses team risk registers to record risks identified from directorate /team /individual work plans. This includes risks that have been removed from the corporate risk register for regular review to ensure that the risks remain in view. Team risks can be escalated to the Corporate Risk Register should the risk change in line with the risk appetite.

During the response to the COVID pandemic the CCG introduced a COVID specific risk register to monitor risks throughout the incident. The COVID risk register was held by the Governance Team and reported to the Executive team, Senior Leadership Team and relevant committees. These risks are continually being reviewed and due to the ongoing nature of the Pandemic response are included in the CCGs corporate risk register for ongoing monitoring and review.

The CCG's risk appetite can be summarised as follows:

The Governing Body of NHS Devon CCG recognises that risk is a natural part of health and social care provision. The CCG will manage and mitigate risk whenever possible, to optimise patient safety. Whenever possible, we will look to take calculated risks where the potential results outweigh the costs.

Risk management is thoroughly embedded in the activity of the CCG, with members of staff engaged as risk owners or risk coordinators.

Risk is an agenda item on all Governing Body assurance committees, any new risk identified through these committees is recorded and appropriate action taken.

Quality and equality impact assessments are integrated into the CCG's core business and form a part of all policies and reports presented to CCG committees and the Governing Body for approval.

The CCG has an incident reporting module through the nursing and quality team and the governance team, where all staff are encouraged to record any incidents arising within the CCG or that relate to the CCG's commissioning work.

ASW Assurance provides an independent counter-fraud service to the CCG. No significant matters of concern have been identified and no investigations have been undertaken.

Capacity to Handle Risk

All CCG staff are involved in risk management – the Executive Director with accountability has responsibility to approve risks onto the CCG corporate risk register and board assurance framework; senior managers as risk-owners with responsibility for ensuring that risks are operationally managed, and, administrative staff as risk-coordinators with responsibility for recording and updating controls, assurances and action plans on the CCGs bespoke corporate risk register.

Guidance on risk management and frequency of training is contained in the CCG's risk management framework policy. The CCG has a risk and governance manager to support the Board Secretary and to provide support to the executive team, training and guidance to the risk coordinators and all other staff members. The Governing Body is assured risk management is effective within the CCG by the Audit Committee. The Audit Committee receives regular reports on risk and the Audit Committee Chair includes the discussion and papers in the chairs report to Governing Body

The use of team risk registers has further strengthened risk management within the CCG by providing a tool for teams/directorates to record and review operational risks identified from directorate /team /individual work plans. This includes risks that have been removed from the corporate risk register on being approved by the responsible Executive these risks are transferred to the Team Risk Register for regular review to ensure that the risks remain in view. Team risks to be escalated to the Corporate Risk Register require Executive approval, as does any recommended change in risk score. Risks escalated to the corporate risk register will result in a risk score change in line with the risk appetite.

Risk Assessment

Risks may be identified at all levels across the CCG, with each being assigned a risk-owner to oversee day-to-day activities, and an executive director to oversee effective management of the risk. Risks are aligned with the CCG's corporate objectives, with an expectation that all parts of the operational plan will have some element of risk associated with them.

Risks are graded according to a standard scoring 5 x 5 matrix, taking account of the CCG's risk appetite. Risks are presented to the relevant committee, the board assurance framework is presented and discussed by the Audit Committee and approved by the Governing Body and included in reports to the executive team.

All relevant risks and their controls are considered during internal audits. The CCG identified 14 new risks and closed a total of 2 risks during the 2021/2022 year, to give a total of 12 open risks remaining as at 31 March 2022. All these risks are reported regularly to the Accountable Officer's Strategic Leadership Team and assurance sought from the Audit Committee prior to a summary being presented to the Governing Body through the Audit Chair's report. Each risk is assigned to a committee of the Governing Body where these committees discuss those risks at each meeting and present their findings to the Governing Body through each committee chair's reports. The CCG's Governing Body papers can be found on the CCG's website. The risks opened during the 2021/2022 year are described in Appendix 2. Risks contained within the board assurance framework at 31 March 2022 will be reviewed as part of transition from CCG to Integrated Care Board and transferred, where appropriate, to the relevant risk register managed by the Board.

Board Assurance Framework (BAF) 2021 to 2022			
CCG Objectives		Board Assurance Framework Risk Ref	Principle Risks <i>There is a risk that.....</i>
1	Commission high-quality and safe services that reduce health inequalities and improve health outcomes		
	We will ensure that we are clear about the outcomes we are commissioning from new and existing services and ensure that contracts are agreed to achieve these.	BAF 1a	We do not commission services based on the outcomes that they will achieve
	We will work with our partners to reduce health inequalities and deliver on the 8 Urgent Actions outlined in Phase 3	BAF 1b	We do not deliver the CCG contribution to the Phase 3 Inequalities action plan
	We will embed the commissioning cycle so that our decision making is based on a strategic evidence base and prioritisation framework	BAF 1c	We do not base our decision making on robust evidence of good practice and strategic intelligence
		BAF 1d	We do not implement a Population Health Management approach throughout the organisation
	We will consider the use of new technology during the process of commissioning new services	BAF 1e	We do not make the most of opportunities to use digital technology
	We will ensure that patient and public views are sought in everything we do	BAF 1f	Our plans do not reflect the views of patients and the public
2	Improve service performance		
	We will ensure that we have robust mechanisms for monitoring progress on delivery of our plans	BAF 2a	The CCG does not meet its statutory requirements and objectives because it does not have effective mechanisms for monitoring progress
		BAF 2b	The System and Locality Care Partnerships do not establish robust mechanisms for performance management
	We will work with our partners to ensure delivery of the operational system plan	BAF 2c	We do not have full commitment from system partners to deliver operational system plan so change is not delivered
	We will have robust processes in place for identifying and responding to emerging risks	BAF 2d	The system does not have robust mechanisms for identifying and responding to emerging risks
	We will deliver the phase 3 restoration plan to maximise planned care during winter and corona virus	BAF 2e	We do not implement the phase 3 restoration plan including maximising planned care during winter and corona virus
	We will deliver the phase 3 restoration plan to maximise planned care during winter and corona virus	BAF 2f	We do not meet our planned elective care activity levels during the first half of the year, due to summer UEC pressures and corona virus (NEW August 2021) H1
	We will deliver the phase 3 restoration plan to maximise planned care during winter and corona virus	BAF2g	We do not meet our planned elective care activity levels during the second half of the year, due to winter UEC pressures and corona virus (NEW December 2021) H2
3	Achieve financial sustainability		
	We will ensure that the CCG delivers a break-even position for 20/21.	BAF 3a	We do not deliver a break-even position for the current financial year.
	We will agree a medium-term plan that will deliver against the financial ambition of the Long Term Plan	BAF 3b	We cannot agree a medium-term plan that will deliver against the financial ambition of the LTP
	We will deliver our agreed efficiency programme for 21/22	BAF 3c	We do not deliver our agreed efficiency programme for 21/22
		BAF 3d	We do not deliver efficiencies from CCG running costs which at least mitigate the cost of inflation and pay progression
4	Be an effective, well-led organisation with an empowered and inclusive workforce		
	We will increase staff satisfaction by addressing the issues raised in the staff survey	BAF 4a	We do not address the issues raised in the staff survey
	We will support staff through the ICS transitions process	BAF 4b	We do not manage the transition process for CCG to ICS well.
	We will achieve an improved NHSE assurance rating	BAF 4c	We do not improve our NHSE Assurance rating
	We will grow and develop our staff to meet their potential and the organisation's needs	BAF 4d	We do not grow and develop our staff to meet their potential and the organisation's needs
	We will increase the diversity of our staff to reflect that of the Devon population	BAF 4e	We do not increase the diversity of our staff to reflect that of the Devon population
5	Lead the system's response to the coronavirus pandemic		
	We will support staff health, wellbeing and morale during the COVID pandemic	BAF 5a	There is a risk that staff will become tired and overworked so we do not have sufficient capacity
	We will deliver our Primary Care strategy to increase capacity and capability in Primary Care	BAF 5b	There is insufficient capacity and capability in Primary Care to meet demand
	We will maintain robust incident management arrangements	BAF 5c	That we do not deliver our function as a system leader because we do not have robust incident management arrangements

Other sources of assurance

Control Issues

A system of internal control is the set of processes and procedures in place in the clinical commissioning group to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The CCG allocates all risks to a named executive director, and a risk owner (who is a senior manager), both of which are supported by a directorate risk coordinator. In addition, a member of the governance team holds a CCG wide overview and coordinates compliance with the Risk Management Framework Policy. All risks are reviewed at least quarterly, with high risks being reviewed no less than monthly. The CCG's risk register is reviewed by each of the CCG's Governing Body committees, either in full or as relevant to the remit of that committee. An annual audit of the risk management process is completed by the CCG's internal auditors, who undertake a review of the CCG's Risk Management arrangements and ensure controls are robustly designed and, in the main, are operating as intended.

Team level risk registers has further supported the management of risk within the CCG by providing a tool to record and monitor operational risk which does not require escalation to the corporate risk register but does ensure executives are aware of risk within their portfolios.

The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness.

The systems of internal control related to risk management are monitored by the governance team to ensure regular reviews of risk are carried out and reporting any breaches should they occur. The risk reports for Governing Body, Audit Committee, Quality Assurance Committee, Finance and Performance Committee, Commissioning Committee, Strategic Leadership Team and Primary Care Committee are produced by the governance team. During 2021/22 no breaches of the policy have been identified.

Annual audit of conflicts of interest management

The revised statutory guidance on managing conflicts of interest for CCGs (published June 2016) requires CCGs to undertake an annual internal audit of conflicts of interest management. To support CCGs to undertake this task, NHS England has published a template audit framework.

The overall objective of this audit was to evaluate the design and operation of the CCG's arrangements and controls for managing conflicts of interest and gifts and hospitality, ensuring compliance with NHS England's managing conflicts of interest statutory guidance for CCGs.

The following specific objectives were covered by this audit:

- The CCG has clear governance arrangements in place to manage conflicts of interest
- Registers for declarations of interest, gifts and hospitality, and procurement decisions are appropriately maintained:

- Clear decisions are made and appropriately documented where senior staff and GB / committee members declare any conflicts:
- Robust procedures are in place to manage breaches of the conflict of interest policy
- CCG registers reconcile to ABPI datasets

As part of the audit consideration was given to the impact of COVID-19 and/or any recovery/restoration or transformation changes to processes or procedures in place for the above areas.

Based on the findings of the audit of conflict of interests completed in quarter 3 2021/2022 the CCG was awarded significant assurance that the controls established by the CCG to manage conflicts of interest, and gifts and hospitality, are appropriately designed and are operating effectively. The CCG's arrangements comply with NHS England's updated statutory guidance for managing conflicts of interest.

We consider that the arrangements and controls established by the CCG to manage conflicts of interest, and gifts and hospitality, are appropriately designed and in the majority of cases, operated as intended.

Data Quality

The Governing Body, in addition to its committees and sub-committees (working groups), receives information provided by the CCG business intelligence team that is sourced from national mandatory returns and NHS Digital information. This data is subject to data quality checks from providers prior to submission, from NHS Digital as part of the national collation process and from the CCG as part of its data management processes. Information is also sourced directly from local providers and this is validated by the CCG business intelligence team on receipt, as well as against national information/guidance when that becomes available. The committee effectiveness reviews undertaken during 2021/22 do not raise any concerns around quality of data.

Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by an information governance toolkit and the annual submission process provides assurances to the clinical commissioning group, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively

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The Data Security & Protection Toolkit (DSPT) submission date for 2020/21 was 30 June 2021. The CCG submitted a baseline submission by the deferred submission date of 28 Feb

2021. The baseline publication is not formally reviewed by NHS Digital as the purpose of the baseline is to provide a status of each organisation's DSPT position. It also served not only to ensure organisations were completing their DSPT but also allowed NHS Digital to review responses to evidence items to assess whether further tooltips or guidance were required. The Data Protection Officer (DPO), following approval from both the Senior Information Risk Owner (SIRO) and Caldicott Guardian, submitted its full 2020/2021 submission in June 2021 as 'Standards Met'. The submission for 2021/2022 due 30 June 2022 will also be as a CCG following the delay in the establishment of Integrated Care Boards/Systems.

The CCG records all risks relating to data security on a risk register and has taken steps to ensure that all data is held securely, as mandated by the UK Data Protection Act and NHS requirements. This includes the risk identified due to the increase in home-working and shared working premises with non-CCG individuals.

As a result of continued improvements for safer working, the CCG has further embedded staff training and, as with previous years, the CCG continues to use the NHS Digital and e-Learning for Health Data Security Awareness training modules via the Electronic Staff Record portal and this continues to form part of the annual mandatory training for all staff. Face-to-face training with teams takes place to give all staff the opportunity to raise questions specific to their roles. The CCG regularly reviews its processes in relation to fair processing, subject access requests, incident reporting and investigation, and updates its Privacy Notice at least every six months, this now includes a section on Covid-19. The Internal Incidents portal available via the icon on every staff member's desktop permits direct and quick access to Datix for the reporting of incidents, breaches and near misses. It provides a consistent approach for all staff for reporting whether that be data protection or for example, health and safety. The ongoing reviews and staff engagement ensured awareness surrounding information risk culture throughout the organisation. The CCG continues to work with its member practices via their Data Protection Officers, Devon Local Medical Committee, providers, community interest company and Local Authorities.

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established a data protection framework and have data protection processes and procedures in line with the DSPT.

In addition to staff training the CCG has implemented a staff information governance handbook as a reference guide to ensure staff are aware of their data protection roles and responsibilities.

The CCG routinely reports any untoward incidents involving personal data to its Data Protection Steering Group which meets every two months and reports are produced for the Audit Committee. No CCG incidents were required to be reported to the Information Commissioner's Office.

The Secretary of State released a Control of Patient Information Notice covering the purposes of sharing information in response to the COVID-19 pandemic. This Notice has subsequently been extended to 30 June 2022 as the pandemic continues. In accordance with the Notice, COVID-19 data, such as data privacy impact assessments, are recorded

separately from business as usual CCG records. Preparations for the upcoming Covid-19 Response Inquiry have begun with the appointment of an Inquiry Lead while we await the Terms of Reference – it should be noted this Inquiry will cover all aspects of the pandemic response such as Education, and not focused solely on just the Health Service.

The Health and Social Care Act 2012 provides NHS Digital with powers to collect personal confidential information. However, the Act does not provide for onward disclosure of identifiable data from NHS Digital. Nationally, a solution was agreed – through a network of Data Services for Commissioners Regional Offices (DSCRO) and supported locally by in house Safe Havens and Controlled Environment for Finance – where only named staff can control access to identifiable data in line with S251. During October 2015, the Health and Social Care (Safety and Quality) Act 2015: Duty to Share Information introduced a new legal duty in which health and adult social care bodies share information where this will facilitate the care of an individual. The CCG has been working with all appropriate bodies to ensure that this is in place and that personal data will only be processed where it is:

- Lawful, fair, and transparent
- Limited to a specified, explicit and legitimate purpose
- Use of minimal data to achieve its purpose
- Accurate and kept up-to-date
- Retained no longer than necessary
- Secured appropriately

The CCG is registered with the ICO ref no: ZA517803

Business Critical Models

An appropriate framework and environment are in place, in line with best practice recommendations of the 2013 MacPherson review, to provide quality assurance of business-critical models – including service planning and provision, budget-setting and allocations. This framework is informed by the role of the Audit Committee and the internal audit programme to review systems of internal control to identify areas for improvement

Third party assurances

As part of its annual plan, the Audit Committee has a rolling programme to gain assurance in respect of the third party providers to which CCG functions are outsourced.

During 2021/22 it reviewed the effectiveness of the controls in relation to our locally outsourced functions, which are NHS Shared Business Services (Finance and Accounting), NHS Digital (General Practitioners payment), NHS Business Services Authority (Prescription and dental payments), Delt (IT services), SW Commissioning Support Unit, Payroll Services and Electronic Staff Records (ESR); these assurances are summarised in the Head of Internal Audit Opinion on page 104.

The CCGs contracting team seeks assurance from providers in relation to all contractual requirements, annually or more often, as required.

Control Issues

The occurrence of COVID-19 pandemic has had a significant impact on the operations of the CCG with a shift of resource to incident management and supporting our stakeholders in delivering services to support the incident response.

The CCG has kept its objectives and priorities under review, in line with national guidance.

Where appropriate, staff (especially clinical staff) have been redeployed. The scheme of delegation has been reviewed. Arrangements for the management of potential fraud and for Information Governance have been reviewed to ensure that they are robust.

The CCG continues to maintain its governance processes with the Governing Body taking on some of the activities of the assurance committees. Agendas have been reviewed and reprioritised where appropriate.

A COVID-19 risk register ensures that the focus is on the current risks and that the approach to risk management is in line with the rapidly changing environment.

Review of economy, efficiency and effectiveness of the use of resources

The Governing Body has responsibility for ensuring that the CCG has appropriate arrangements in place to manage its functions economically, efficiently and effectively. The Governing Body makes sure that the CCG operates within the corporate governance framework (i.e. its standing orders, scheme of delegations and standing financial instructions) and has established an Audit Committee to assist the Governing Body in delivering its responsibilities for the conduct of public business, and the stewardship of funds under its control, and a Finance and Performance Committee to provide a performance framework that proactively manages the CCG's financial and performance agendas.

The Quality Assurance Committee have in place a quality assurance process which measures quality against the 5 domains of the Care Quality Commission. In addition, there are Quality, equality, inclusion assessments (QEIA) and local key performance indicators in relation to quality and performance.

The Audit Committee provides assurance to the Governing Body that an appropriate system of internal control is in place to ensure that:

- Business is conducted in accordance with the law and proper standards
- Public money is safeguarded and properly accounted for
- Affairs are managed to secure economic, efficient and effective use of resources
- Reasonable steps are taken to prevent and detect fraud and other irregularities

The CCG has a procurement policy that seeks to be an effective way to help ensure quality and value for money requirements are achieved; helping the CCG commission the right services to improve the lives of those who live in Devon.

The CCG make full use of internal and external audit functions to confirm controls are operating effectively, to provide independent assurance and advise on areas of improvement. Audit report findings are discussed in detail at Audit Committee and summarised in the Head of Internal Audit Opinion Statement.

The Chief Finance Officer provides routine financial performance reports to the CCG's Finance and Performance Committee, as well as Governing Body, including performance against the organisation's statutory financial duties.

In 2021/22 NHS England continued the financial regime, introduced in 2020/21 due to COVID, that CCGs were required to follow. Funding included adjustments for inflation, efficiency requirements and policy priorities, as well as an allocation for COVID.

The CCG produced a plan in line with NHSE's guidance which required £15.2m additional savings. The CCG was able to deliver the required efficiencies to end the year with a surplus of £5.28m.

Delegation of functions

Responsibility for each duty and power has been clearly allocated to a lead executive director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the CCG's statutory duties.

The CCG's Governing Body may also have functions delegated to it by the membership of the CCG. These are set out in the articles of the constitution, scheme of reservation and delegation or the standing orders.

The Governing Body undertakes some of its work through its committees. Each committee has terms of reference, which have been formally approved by the Governing Body. Committee chairs present summaries, through their Chair's report, of the key business conducted at their meetings at subsequent meetings of the Governing Body held in public.

Value for money is assured through procurements which follow national and NHS guidelines. The appropriate legal and professional procurement advice is sought at all times which keeps the appropriate focus on patient safety quality and care as well as value for money.

Led by the Audit Committee, a risk-based audit plan is developed and detailed scrutiny and checking of systems and procedures are undertaken by internal audit and counter fraud services. At a more strategic level external audit also check and provide assurance on a number of key areas as well as the annual accounts.

The Governing Body receive reports from the finance team at each meeting and have devolved detailed scrutiny of all finance issues through the finance and performance committee.

Compliance with NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR)

NHS Devon CCG reported their compliance against the NHS England Core Standards for EPRR to the Governing Body during Q3 on 25 November 2021. NHS Devon CCG was assessed as Fully Compliant. Papers can be found here for full details:

<https://devonccg.nhs.uk/documents?wpdmc=meeting-papers-and-minutes>

Counter fraud arrangements

ASW Assurance and their accredited Counter Fraud Specialists provide an independent counter-fraud service to the CCG. No significant matters of concern have been identified.

The Audit Committee receives regular reports from the Counter Fraud team and provides assurance to the Governing Body that an appropriate system of internal control is in place to ensure reasonable steps are taken to prevent and detect fraud and other irregularities.

Head of Internal Audit Opinion

The Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the clinical commissioning group's system of risk management, governance and internal control. The Head of Internal Audit concluded that:

Significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. Some weaknesses in the design and/or inconsistent application of controls put the achievement of particular objectives at risk. Weaknesses in the design and/or inconsistent application of controls, which put the achievement of particular objectives at risk, are appropriately managed.

The following Internal Audit reports were included within the Head of Internal Audit Opinion. In preparing the Head of Internal Audit Opinion, Internal Audit also considered the CCG's Strategic Governance, Transition, Information Governance and Cyber Security arrangements and third party assurances

Area of Audit and Level of Assurance Given

Managing Conflicts of Interest	Significant
Business Continuity Arrangements	Significant
Assurance Framework and Risk Management Arrangements	Significant
Financial Systems Controls	Significant
Transition Due Diligence Part 1	Significant
Financial Management and Cost Improvement Plan	Significant
Safeguarding	Satisfactory

Review of the effectiveness of governance, risk management and internal control

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive managers and clinical leads within the clinical commissioning group who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their annual audit letter and other reports.

Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the clinical commissioning group achieving its principles objectives have been reviewed.

I have been advised on the implications of the result of this review by:

- The board
- The audit committee
- If relevant, the risk / clinical governance / quality committee
- Internal audit
- Other explicit review/assurance mechanisms.

Conclusion

In line with the HIAO I can confirm that no significant internal control issues have been identified and that the CCG's risk management arrangements are appropriately designed and are operating as intended in respect of the management and monitoring of strategic and corporate level risks.



Jane Milligan
Accountable Officer
NHS Devon Clinical Commissioning Group

27 April 2022

Remuneration and staff report

Remuneration report

Remuneration committee

The remuneration committee fulfils the remuneration committee functions required by statute, principally to determine remuneration, fees and allowances payable to CCG staff, and make recommendations to the governing body. As well as this, the committee deals with remuneration and terms of service in relation to the governing body and the executive team.

The remuneration committee consists of all non-executive lay members, a secondary care doctor, the CCG Chair (non-voting) and a GP representative of the governing body. The quorum constitutes of a minimum of three non-executive lay members and a clinical representative. The committee is advised by the Director of Communications and Human Resources and the Associate Director of Human Resources and Organisational Development and, where required, the Chair and the Accountable Officer of the CCG.

Statement on policy for remuneration, now and future

Some senior managers are on the NHS Agenda for Change framework, while others are in line with the Department of Health Pay Framework for very senior managers framework.

The remuneration of senior managers is reviewed annually in conjunction with advice and guidance received from NHS Partners and the Department of Health and will include review of the assessment of performance during the relevant financial period including achievement of specific performance targets.

All governing body members have contracts of employment with the CCG, with appropriate notice periods built into each contract. This is in line with guidance received from the Department of Health and HM Revenue and Customs.

Redundancy clauses in each contract match the provisions in the Agenda for Change contract of employment.

Senior managers' performance related pay

Devon CCG does not have performance related pay.

Senior manager remuneration (including salary and pension entitlements) 2021/22 (audited)

Name and Title	Note	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
		£000	£	£000	£000	£000	£000
Alison Davis Non Executive Director		5-10				0	5-10
Andrew Millward Chief Communications, IT and People Officer	1	65-70				27.5-30	95-100
Charlotte Burrows Lay Member - Patient and Public Involvement	2	5-10				0	5-10
Darryn Allcorn Nursing Chief Nursing Officer		130-135				35-37.5	165-170
David Greenwell Clinical representative (southern)		25-30				5-7.5	30-35
Gaynor Appleby Lay Member - Allied Healthcare		10-15				0	10-15
Glynis Atherton Lay Member - Assuring Quality of Services		10-15				0	10-15
Graham Turner Lay Member - Finance and Remuneration		10-15				0	10-15
James Wooldridge Associate Non Executive Director	3	0-5				0	0-5
Jane Milligan Accountable Officer	4	190-195	1,000			257.5-260	445-450
Jayne Carroll Interim Chief Operating Officer	5	20-25				57.5-60	75-80
Jo Turl Executive Director of Out of Hospital commissioning		120-125				30-32.5	150-155
John Dowell Chief Finance Officer		130-135				0-2.5	130-135
John Finn Executive Director of In Hospital commissioning	6	125-130				92.5-95	215-220
John Womersley Clinical representative (Northern)		85-90				0	85-90
Judith Hargadon Lay Member - Primary Care and Prevention		10-15				0	10-15
Nick Ball Lay Member - Audit and Assurance		25-30				0	25-30
Nick Kennedy Secondary care doctor		55-60				0	55-60
Paul Johnson Clinical Chair		135-140	100			7.5-10	140-145
Shelagh McCormick Clinical representative (Western)		85-90				25-27.5	110-115

Simon Kerr Clinical representative (Eastern)		60-65				22.5-25	85-90
Simon Tapley Deputy Accountable Officer		140-145				32.5-35	175-180

Note

1. Andrew Milward is also Systems Director of Communications & Engagement, only CCG Director of Communications & HR salary disclosed which is 50%
2. Charlotte Burrows finished role on 30th November 2021
3. James Wooldridge finished role on 12th October 2021
4. Jane Milligan began role on 1st April 2021. The pension related benefits have been calculated using the mid-point of the 2020/21 pension bands.
5. Jayne Carroll finished role on 31st May 2021
6. John Finn began role on 27th January 2021

Additional governing body members and attendees not receiving remuneration from Devon CCG are as follows

Steve Brown is a director of Public Health for Devon County Council and is a co-opted member. No payments are made for attendance.

Ruth Harrell is a Director of Public Health for Plymouth and is a co-opted member. No payments are made for attendance.

Lincoln Sargeant is a director of Public Health for Torbay and is a co-opted member. No payments are made for attendance.

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less, the contributions made by the individual.

The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights.

This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide.

The pension benefit table provides further information on the pension benefits accruing to the individual.

Factors determining the variation in the values recorded between individuals include but is not limited to:

A change in role with a resulting change in pay and impact on pension benefits

A change in the pension scheme itself

Changes in the contribution rates

Changes in the wider remuneration package of an individual

Pension benefits relate to the total employment with Devon CCG even if the member has a split role but are pro rata to time spent in senior management position.

Senior manager remuneration (including salary and pension entitlements) 2020/21 (audited)

Name and Title	Note	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
		£000	£	£000	£000	£000	£000
Darryn Allcorn Chief Nursing Officer	1	115-120				55-57.5	170-175
Gaynor Appleby Lay Member - Allied Healthcare		10-15					10-15
Glynis Atherton Lay Member - Assuring Quality of Services		10-15					10-15
Nick Ball Lay Member - Audit and Assurance		25-30					25-30
Charlotte Burrows Lay Member - Patient and Public Involvement		10-15					10-15
Jayne Carroll Interim Chief Operating Officer	2	80-85				12.5-15	95-100
Alison Davis Associate Non Executive Director		5-10					5-10
John Dowell Chief Finance Officer		140-145	100			30-32.5	170-175
John Finn Interim executive director of commissioning - in-hospital	3	20-25				5-7.5	25-30
David Greenwell Clinical representative (southern)		25-30				5-7.5	30-35
Judith Hargadon Lay Member - Primary Care and Prevention		10-15					10-15
Paul Johnson Chair		125-130				25-27.5	150-155
Nick Kennedy Secondary Care Doctor		55-60					55-60
Simon Kerr Clinical representative (Eastern)		60-65					60-65
Philip King Interim Chief Nursing Officer	4	45-50				10-12.5	60-65
Sonja Manton Accountable Emergency Officer	5	120-125				35-37.5	155-160
Shelagh McCormick Clinical representative (Western)		85-90	100			0-2.5	90-95
Andrew Millward Director of Communications and HR	6	70-75				22.5-25	95-100
Simon Tapley Interim Accountable Officer		145-150				65-67.5	210-215
Sarah F Thompson Interim Chief Operating Officer	7	55-60				95-97.5	150-155

Jo Turl Director of Commissioning (western) / Director of out-of-hospital commissioning		120-125				67.5-70	190-195
Graham Turner Lay Member - Finance and Remuneration		10-15					10-15
Lorraine Webber Interim Director of Nursing	8	10-15					10-15
John Womersley Clinical representative (Northern)		85-90					85-90
James Wooldridge Associate Non Executive Director		5-10					5-10

Note

- 1 Darryn Allcorn began role on 11th May
- 2 Jayne Carroll began role on 1st August
- 3 John Finn began role on 27th January
- 4 Phillip King began role on 17th March 2020 and ended on 31st August
- 5 Sonja Manton ceased to be a voting member 31st March
- 6 Andrew Milward is also Systems Director of Communications & Engagement, only CCG Director of Communications & HR salary disclosed which is 50%
- 7 Sarah F Thompson finished role on 18th September
- 8 Lorraine Webber ended interim role on 12th May

Additional governing body members and attendees not receiving remuneration from Devon CCG

Dr Virginia Pearson is a director of Public Health for Devon County Council and is a co-opted member. No payments are made for attendance

Ruth Harrell is a Director of Public Health for Plymouth and is a co-opted member. No payments are made for attendance

Caroline Diamond was a director of Public Health for Torbay until February 2021 and is a co-opted member. Lincoln Sargeant took over this role in February 2021. No payments are made for attendance

Pension benefits – 2021/22 (audited)

Name and Title	(a) Real Increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age at 31 March 2022 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31 March 2022 (bands of £5,000)	(e) Cash Equivalent Transfer Value at 1 April 2021	(f) Real increase in Cash Equivalen t Transfer Value	(g) Cash Equivalent Transfer Value at 31 March 2022	(h) Employer's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Andrew Millward Chief Communications, IT and People Officer	2.5-5	0	50-55	125-130	1,093	41	1,160	0
Darryn Allcorn Nursing Director/ Chief Nursing Officer	2.5-5	0-2.5	45-50	95-100	751	32	805	0
David Greenwell Clinical representative (southern)	0-2.5	0	10-15	20-25	197	7	210	0
Jane Milligan Accountable Officer	12.5-15	30-32.5	65-70	145-150	1,015	284	1,332	0
Jayne Carroll Interim Chief Operating Officer	2.5-5	0	35-40	90-95	722	56	790	0
Jo Turl Executive Director of Out of Hospital commissioning	0-2.5	0-2.5	30-35	60-65	460	18	497	0
John Dowell Chief Finance Officer	0-2.5	0	65-70	100-105	1,125	18	1,168	0
John Finn Executive Director of In Hospital commissioning	5-7.5	0	25-30	0-5	370	29	419	0
Paul Johnson Clinical Chair	0-2.5	0	30-35	65-70	529	2	558	0
Shelagh McCormick Clinical representative (Western)	0-2.5	0-2.5	15-20	35-40	338	25	378	0
Simon Kerr Clinical representative (Eastern)	0-2.5	0-2.5	20-25	45-50	424	28	463	0
Simon Tapley Deputy Accountable Officer	2.5-5	0	55-60	115-120	924	33	982	0

Note

No CETV will be shown for pensioners or senior managers over NPA. Age 60 in the 1995 Section, age 65 in the 2008 Section or SPA or age 65, whichever is the later, in the 2015 Scheme.

- Lay members do not receive pensionable remuneration; there are no entries in respect of pensions for lay members.
- Only members with an NHS pension have been included.
- Pension benefits have not been included for those who are currently drawing their NHS pension.

Pension benefits – 2020/21 (audited)

Name and Title	(a) Real Increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age at 31 March 2021 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31 March 2021 (bands of £5,000)	(e) Cash Equivalent Transfer Value at 1 April 2020	(f) Real increase in Cash Equivalent Transfer Value	(g) Cash Equivalent Transfer Value at 31 March 2021	(h) Employer's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Darryn Allcorn Chief Nursing Officer	2.5-5	2.5-5	45-50	90-95	671	51	751	0
Jayne Carroll Chief Operating Officer	0-2.5	0	30-35	90-95	664	20	722	0
John Dowell Chief Finance Officer	2.5-5	0	65-70	100-105	1047	40	1125	0
John Finn Interim executive director of commissioning - in-hospital	0-2.5	0-2.5	20-25	25-30	327	4	370	0
David Greenwell Clinical representative (southern)	0-2.5	0-2.5	5-10	20-25	183	7	197	0
Paul Johnson Chair	0-2.5	0-2.5	25-30	65-70	478	19	529	0
Simon Kerr Clinical representative (Eastern)	0-2.5	0	20-25	45-50	409	0	424	0
Philip King Interim Chief Nursing Officer	0-2.5	0-2.5	0-5	5-10	68	7	84	0
Sonja Manton Accountable Emergency Officer	2.5-5	0-2.5	25-30	35-40	301	17	341	0
Shelagh McCormick Clinical representative (Western)	0-2.5	0	15-20	35-40	320	0	338	0

Andrew Millward Director of Communications and HR	0-2.5	0	45-50	125-130	1021	34	1093	0
Simon Tapley Interim Accountable Officer	2.5-5	2.5-5	50-55	115-120	832	57	924	0
Sarah F Thompson Chief Operating Officer	2.5-5	12.5-15	50-55	150-155	0	0	0	0
Jo Turl Director of Commissioning (western) / Director of out-of-hospital commissioning	2.5-5	0-2.5	30-35	60-65	400	35	460	0
Lorraine Webber Interim Director of Nursing	0	0	35-40	85-90	708	0	677	0

Taxable expenses

No expenses, other than reimbursement of those actually incurred and in support of training and development of Senior Managers, have been paid.

Expenses, all of which relate to mileage claims and relocation costs, give rise to a tax liability and have been disclosed separately as benefits in kind. The tax liability arises as either the rate per mile reimbursed by the CCG exceeds that allowed as a tax-free amount by HMRC, or the total annual amount paid by the CCG exceeds that allowed as a tax-free amount by HMRC respectively.

Cash equivalent transfer values

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation (0.5%), contributions paid by the employee

(including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Payments on early retirement or for loss of office

There was no payment for early retirement or payment for loss of office during 2021/22, or during 2020/21.

Payments to past senior managers

There were no awards made to past senior managers in-year.

Pay multiples

	Percentage change for the highest paid director	Percentage change for employees as a whole
Salary and allowances	31%	1%
Performance pay/bonuses	N/A	N/A

Reporting bodies are required to disclose annual percentage changes in remuneration of the highest paid director and employees.

The highest paid director's salary has increased by 31% in 2021/22 to £192,500 (2020/21, £147,500). The increase in salary is due to the new Chief Executive salary scale for the new Integrated Care Boards.

The average salary for employees as a whole has increased by 1% in 2021/22 to £49,823 (2020/21, £49,337). This is calculated for 2021/22 from a total annualised salary of £28,747,613 for a total number of staff of 575 (2020/21, £27,530,181 for 558). The increase is influenced by the 3% NHS salary pay rise implemented by the government for 2021/22.

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director/member in their organisation and the 25th percentile, median (50th percentile) and 75th percentile of remuneration of the organisation's workforce.

	2021/22 Remuneration £	Pay multiple Ratio	2020/21 Remuneration £	Pay multiple Ratio
Highest paid director	192,500		147,500	
Staff (excluding above)				
25th Percentile	24,882	7.74	24,157	6.11
Median	42,121	4.57	40,894	3.61
75th Percentile	63,862	3.01	62,001	2.38

The banded annualised remuneration of the highest-paid member of the Governing body in Devon CCG in the financial year 2021/22 was £190,000-£195,000 (2020/21, £145,000-£150,000). As mentioned above the increase in salary is due to the new Chief Executive salary scale for the new Integrated Care Boards.

Firstly, this was 7.74 times (2020/21, 6.11) the 25th percentile of remuneration of the workforce, which was £24,882 (2020/21, £24,157). Secondly, this was 4.57 times (2020/21, 3.61) the median remuneration of the workforce, which was £42,121 (2020/21, £40,894). Finally, this was 3.01 times (2020/21, 2.38) the 75th percentile of remuneration of the workforce, which was £63,862 (2020/21, £62,001).

In 2021/22, 0 (2020/21, 1) employees received remuneration in excess of the highest-paid director. Remuneration ranged from £13,943 to £190,000 (2020/21, £13,536 to £147,480).

Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

Staff report

The CCG takes pride in the strength and commitment of its workforce which exhibits an effective range of skills, abilities, and experience across all of our functions. It continues to support and develop its workforce to ensure we are responsive and adaptable to the changing political environment and the continued need to work more closely with system partners across Devon.

Staff numbers and costs (draft)

As of 31 March 2022, the CCG employed 564 individuals in a full-time equivalent of 494.82 posts.

Governing Body

As of 31 March 2022, the governing body had a total of 19 members, of which 63 per cent are men (12), and 37 per cent are women (7).

Directors and Senior CCG managers

Pay grade	Contract	Female	Male	Headcount	FTE
VSM	Permanent	2	5	7	7
	Other	1	1	2	1.8
Band 9	Permanent	4	6	10	10
	Other	1	0	1	1
Total		8	12	20	19.8

Note: Figures above do not include those staff hosted by the CCG who are employed as part of the Integrated Care System.

All staff

The following table describes the staff composition in terms of banding, contract type and gender.

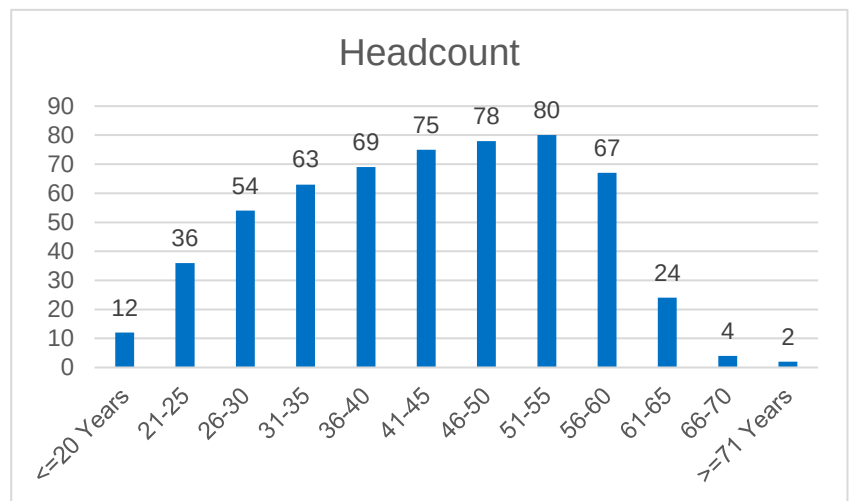
Pay grade	Contract	Female	Male	Headcount	%	FTE
Band 2	Permanent	2	0	2	0.35	1.93
	Other	6	3	9	1.60	8.80
Band 3	Permanent	72	12	84	14.89	75.72
	Other	6	2	8	1.42	7.60
Band 4	Permanent	45	10	55	9.75	51.75
	Other	2	0	2	0.35	1.76
Band 5	Permanent	54	8	62	10.99	56.95
	Other	0	0	0	0.00	0.00
Band 6	Permanent	30	9	39	6.91	36.28
	Other	1	1	2	0.35	1.60
Band 7	Permanent	45	21	66	11.70	61.29
	Other	5	3	8	1.42	6.76
Band 8 - Range A	Permanent	48	20	68	12.06	62.02
	Other	4	4	8	1.42	6.57
Band 8 - Range B	Permanent	26	9	35	6.21	32.64
	Other	2	0	2	0.35	2.00
Band 8 - Range C	Permanent	22	11	33	5.85	32.40
	Other	3	0	3	0.53	3.00
Band 8 - Range D	Permanent	5	4	9	1.60	9.00
	Other	0	0	0	0.00	0.00
Band 9	Permanent	6	7	13	2.30	12.81
	Other	1	0	1	0.18	1.00
Other non AFC	Permanent	22	14	36	6.38	15.43
	Other	7	12	19	3.37	7.51
Grand Total		414	150	564	100.00 %	494.82

**Note: Where staff have more than one role across different bands or categories their headcount is duplicated. Figures exclude Non-Executive Directors/ Lay Governing Body Members.*

The below tables and charts illustrate our distribution of staff by age as of 31 March 2022.

Staff age and gender

Age Band	Headcount	FTE
<=20 Years	12	11.93
21-25	36	35.35
26-30	54	50.36
31-35	63	57.27
36-40	69	62.77
41-45	75	60.35
46-50	78	63.31
51-55	80	71.93
56-60	67	60.15
61-65	24	17.51
66-70	4	2.29
>=71 Years	2	1.60
Grand Total	564	494.82



The below table illustrates our distribution of staff by gender identity as of 31 March 2022.

<i>Gender</i>	<i>Headcount</i>	<i>FTE</i>
Staff who identify as female	414	359.26
Staff who identify as male	150	135.56
Grand Total	564	494.82

The table below illustrates our employee distribution relating to staff group as of 31 March 2022.

<i>Staff Group</i>	<i>Headcount</i>	<i>FTE</i>
Add Prof Scientific and Technic	36	30.37
Administrative and Clerical	439	411.21
Allied Health Professionals	5	3.84
Medical and Dental	41	10.14
Nursing and Midwifery Registered	43	39.25
Grand Total	564	494.82

Staff costs

The table below sets out the breakdown of employee benefits for 2021/22.

2021/22	Total			Admin			Programme		
	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000
Salaries and wages	22,725	20,462	2,263	12,268	11,834	434	10,457	8,628	1,829
Social security costs	2,343	2,343	0	1,496	1,496	0	847	847	0
Employer Contributions to NHS Pension scheme	4,249	4,249	0	3,072	3,072	0	1,177	1,177	0
Other pension costs	5	5	0	5	5	0	0	0	0

Apprenticeship Levy	82	82	0	82	82	0	0	0	0
Other post-employment benefits									
Other employment benefits									
Termination benefits	0	0	0	0	0	0	0	0	0
Gross employee benefits expenditure	29,404	27,141	2,263	16,923	16,489	434	12,481	10,652	1,829
Less recoveries in respect of employee benefits									
Net admin employee benefits including capitalised costs	29,404	27,141	2,263	16,923	16,489	434	12,481	10,652	1,829
Less: employee costs capitalised									
Net employee benefits excluding capitalised costs	29,404	27,141	2,263	16,923	16,489	434	12,481	10,652	1,829

Staff policies (equalities, diversity and inclusion)

The CCG has a range of human resources policies in place to ensure clear, fair and transparent practices that cover all aspects of the CCG. All policies are approved by the Staff Partnership Forum and Executive and are available to all staff on our intranet.

Equalities issues are incorporated into policies covering all aspects of human resources to ensure that individuals are treated equally and fairly, and that decisions on recruitment, selection, training, promotion and career management are based solely on objectives and job-related criteria. The CCG's aims are to promote diversity and equality of opportunity and provide an inclusive working environment in which all staff feel valued and supported.

We are an accredited “Disability Confident” employer, which ensures all applicants who have declared that they have a disability are guaranteed an interview if they meet the essential requirements of the person specification of a role. The Recruitment policy and process outlines the requirements for recruiting managers to make reasonable adjustments for candidates with disabilities and this is reinforced through recruitment training courses run for all staff who are required to sit on recruitment panels. All staff with a declared disability or who become disabled during their employment will have access to appropriate training courses, and career development opportunities, and access to promotional opportunities. Reasonable adjustments are made to support these people with accessing and benefitting from these opportunities.

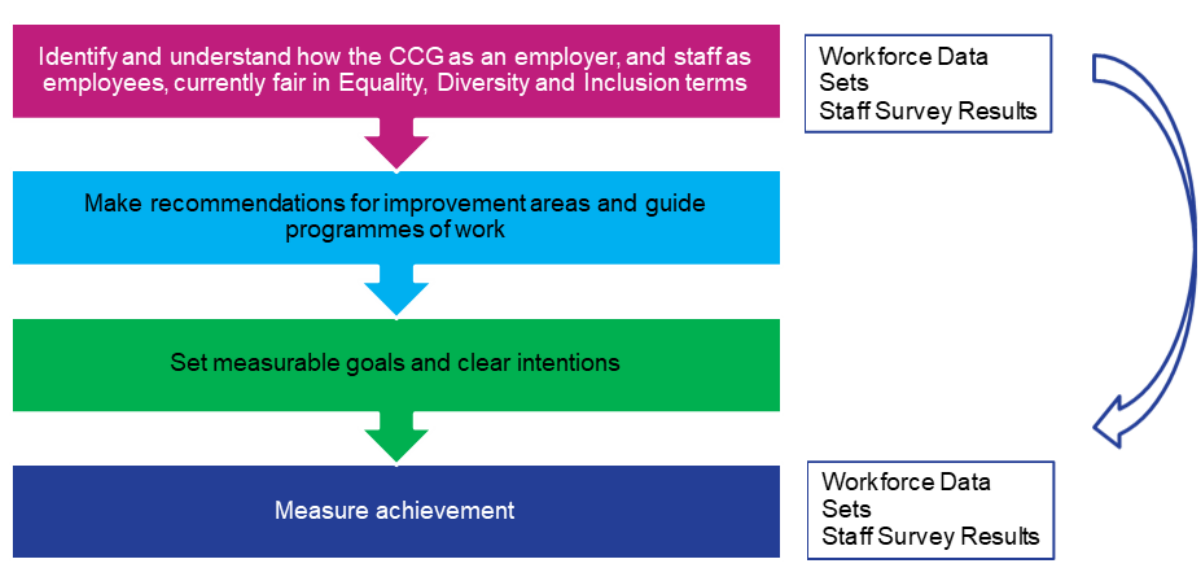
All our policies that relate to the continued employment and training of staff with disabilities have been equality impact assessed to ensure they are not detrimental to any staff with protected characteristics, including persons with disabilities. All policies are developed in line with Agenda for Change Terms and Conditions where applicable.

The 2021 Workforce Race Equality Standard (WRES) report is published on the CCG's website. This report provides statistics and information about the ethnicity of the CCG's workforce. Over the past three years between 1% and 2% of the CCG's workforce has been designated as being from a Black, Asian and Minority Ethnic (BAME) background in our employee records system. The 2011 census reported a 3% BAME population in Devon as a whole, so the composition of the CCG's workforce is slightly out of kilter with the wider population of Devon.

The 2021 WRES report also includes an action plan which describes the key actions and initiatives that the CCG is taking to address this imbalance. In 2020, the CCG commissioned the Nous consultancy to identify ways of improving the recruitment and promotion of people from a BAME background. Nous's recommendations continue to be incorporated in a system-wide plan for improvements.

The CCG also recently employed a System Equality Diversity and Inclusion Lead, a post which will focus specifically on equality and diversity policies and initiatives within the CCG and the Devon system as a whole.

The CCG also has a staff Equality, Diversity & Inclusion Group which influences and leads change projects within the staff base to increase knowledge and visibility of EDI issues, create a more diverse workforce and improve overall staff wellbeing and satisfaction. The group is a sub-group of the Staff Partnership Forum and is accountable to the CCG Strategic Workforce & Remuneration Committee. The approach applied by the EDI group is illustrated by the below graphic:



In addition, the CCG continues to monitor providers compliance with the workforce race equality standard, the accessible information standard and the new sexual orientation monitoring standard.

Trade Union Facility Time Reporting Requirements

The Trade Union (Facility Time Publication Requirements) Regulations 2017 took effect on 1 April 2017, this means that NHS employers are now required to publish certain information on trade union officials and facility time on their website and within annual reports.

The information provided below is for the relevant period of 1 April 2021 to 31 March 2022. It captures details of employee's time spent on duties carried out for a trade union or as a union learning representative, for example, attending meetings, accompanying an employee to disciplinary or grievance hearing etc. It also applies to, if applicable, training received, and duties carried out under the Health and Safety at Work Act 1974.

It is important to note that the CCG's formal consultation mechanism is through the Staff Partnership Forum. Representatives of the forum are staff members who are not required to be part of a Trade Union or indeed be a representative of a Trade Union and therefore this information does not reflect staff time spent on forum duties.

Table 1: the number of trade union representatives in your organisation

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
1	1

Table 2: the percentage of time spent on facility time

Percentage of time	Number of employees
0%	0
1-50%	1
51-99%	0
100%	0

Table 3: the amount spent on facility time

First column	Figures
Provide the total cost of facility time	£573.60
Provide the total pay bill	£18,898,407.00
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time/total pay bill) x 100	0.003%

Table 4: the percentage of paid facility time spent on paid trade union activities

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period/total paid facility time hours) x 100	100% (28 hours)
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Other employee matters

Staff health and wellbeing

We are committed to the health and wellbeing of our staff through preventive and promotional support through our staff-led health and wellbeing programme which aims to:

- create and encourage an ongoing dialogue across the organisation to improve staff health and wellbeing
- raise awareness and provide useful information & resources
- organise staff events and workshops that encourage colleagues to improve their health and wellbeing
- link initiatives back to our own colleagues and values by sharing personal and team stories

A Wellbeing Guardian has been appointed from the CCG's Board and Health and Wellbeing Champions continue to develop and implement the health and wellbeing programme. This year initiatives continued to support our staff, and the NHS response to the pandemic and included:

- A variety of offers to staff in the form of training; workshops; promotion of online tools and resources;
- Provision and promotion of the Employee Assistance Programme (EAP) for health and care staff across Devon, including Primary Care and Adult Social Care;
- Mindfulness, yoga and fitness classes;
- Commissioning of a wellbeing support programme which will commence in 2022;
- Individual wellbeing check-in conversations with staff carried out by the Health and Wellbeing; Champions, Mental Health First Aiders (MHFA), Executive Team, Staff Partnership Forum members, Freedom To Speak Up Guardians, and members of the Human Resources Team;

- Promotion of staff wellbeing initiatives and personal stories in fortnightly staff briefings led by the Accountable Officer and Executive Team.

Staff policies

The CCG has policies in place to provide guidance to all employees. All human resource policies have been written to ensure equality and diversity is upheld in the workplace. All policies align to Agenda for Change terms and conditions, statutory guidance and HR best practice. Staff turnover figures for the CCG are included in the [NHS workforce statistics](#) reported on the NHS Digital website. Staff absence figures are included in the [NHS sickness absence rates](#) report published on the NHS Digital website.

Employee engagement

The CCG is committed to involving and communicating with staff across a range of matters. This is through a variety of channels such as our weekly staff bulletin and monthly briefings, as well as:

- the Staff Partnership forum
- an annual staff awards event
- the promotion of health and wellbeing, including a monthly newsletter
- a new and improved induction programme

In 2019 the NHS Staff Survey engagement score for the CCG was 6.8 out of 10. In 2020, this score increased to 7.1 and in 2021 it remained at 7.1.

Development of our staff

The Organisational Development team works closely with leaders, clinicians managers and staff to ensure that we meet the development needs of staff and the organisation to deliver the CCG objectives. In 2021/22 we have developed and delivered the CCG People Plan which has included:

- Supported individual teams to address areas of development highlighted in the 2020/21 Staff Survey
- Delivered a comprehensive wellbeing programme to support all staff during and beyond the pandemic, including health and wellbeing check-ins offered to all staff; training; workshops; promoting local and national resources and making these available to staff on a dedicated health and wellbeing intranet page
- Supported twenty apprentices across the last 12 months
- Supported three graduate trainees as part of the Graduate Management Training Scheme partnership arrangement
- Integrated a talent management approach into the CCG's Developing and Growing our People Policy.
- Commissioned and delivered a number of bespoke training programmes for staff that were well attended and based on development needs identified in the appraisal process.
- Governing Body and Executive Director development programmes designed and delivered for non executives, clinicians, and executives
- Appraisal plus completion rate for staff appraisals was 69.53%

The CCG is also committed to ensuring all staff have completed their statutory and mandatory training. The completion rate is currently 85.30%

Off-payroll engagements

Table 1: Length of all highly paid off-payroll engagements as at 31 March 2022.

For all off-payroll engagements as at 31 March 2022 for more than £245* per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2022	4
<i>Of which, the number that have existed:</i>	
for less than one year at the time of reporting	3
for between one and two years at the time of reporting	1
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

*The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

The CCG confirms that all existing off-payroll engagements have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

Table 2: Off-payroll workers engaged at any point during the financial year

For all off-payroll engagements between 1 April 2021 and 31 March 2022, for more than £245(Note 1) per day:

	Number
No. of temporary off-payroll workers engaged between 1 April 2021 and 31 March 2022	6
<i>Of which:</i>	
No. not subject to off-payroll legislation ^(Note 2)	0
No. subject to off-payroll legislation and determined as in-scope of IR35 ^(Note 2)	0
No. subject to off-payroll legislation and determined as out of scope of IR35 ^(Note 2)	6

the number of engagements reassessed for compliance or assurance purposes during the year	0
Of which: no. of engagements that saw a change to IR35 status following review	0

Notes:

1 - The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

2 - A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Department must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes.

Table 3: Off-payroll engagements/senior official engagements

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year (Note 1)	0
Total no. of individuals on payroll and off-payroll that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the financial year. This figure should include both on payroll and off-payroll engagements (Note 2)	19

Notes:

1 - There should only be a very small number of off-payroll engagements of board members and/or senior officials with significant financial responsibility, permitted only in exceptional circumstances and for no more than six months

2 - If both on payroll and off-payroll engagements are included in the total figure, no entries here should be blank or zero.

In any cases where individuals are included within the first row of this table the CCG should set out:

- Details of the exceptional circumstances that led to each of these arrangements.
- Details of the length of time each of these exceptional engagements lasted.

Exit packages, including special (non-contractual) payments

Exit packages are agreements made in year for payments to employees on termination of employment. These include the additional costs where the CCG has agreed early retirements.

There were no exit packages agreed in 2021/22.

Expenditure on consultancy

During 2021/22 the CCG spent £1.646m on external consultancy costs (£2.455m in 2020/21).

Parliamentary accountability and audit report

NHS Devon CCG is not required to produce a Parliamentary Accountability and Audit Report. Included, as notes, are disclosures on contingencies (see page 126) and special payments (see page 96). An audit certificate and report are also included on page 10

Appendix 1

Meeting attendance and membership of NHS Devon Clinical Commissioning Group Governing Body 2021/22

			Governing Body	Audit	Finance & Performance	Primary Care	Quality Assurance	Remuneration & Workforce	Commissioning Committee
Total Number of Meetings			11	7	8	12	10	7	10
Voting Member Name	Role	Note	Number of Meetings Attended						
CCG Chair									
Paul Johnson	Clinical Chair	All attendances counted, including non-voting	10	N/A	1	5	N/A	1	0

Alison Davis	Non- Executive Director		11	N/A	N/A	N/A	3	1	N/A
Charlotte Burrows	Non-executive lay member (patient and public involvement)	Left Nov 21	3	N/A	N/A	6	4	3	N/A
Gaynor Appleby	Non-Executive Lay Member (Allied Healthcare)		10	N/A	N/A	4	9	0	N/A
Glynis Atherton	Non-executive Lay Member (assuring quality of services)		8	N/A	N/A	10	7	5	N/A
Graham Turner	Non-Executive Lay Member (Finance and Remuneration)		11	7	8	N/A	N/A	4	N/A
James Woolridge	Associate Non-Executive Director	With the organisation until Oct 21	4	N/A	N/A	N/A	N/A	N/A	N/A

Judith Hargadon	Non-executive Lay Member (primary care and prevention)		9	6	N/A	12	N/A	3	N/A
Nick Ball	Non-executive Lay Member (Financial Management and Audit)		10	7	9	8	N/A	5	N/A
Executives									
Andrew Millward	Chief Communications, IT and People Officer		10	N/A	N/A	N/A	N/A	4	N/A
Darryn Allcorn	Chief Nurse		10	N/A	1	0	8	N/A	1
Ginny Snaith	Board Secretary		11	5	1	N/A	1	0	1
Jayne Carroll	Interim Chief Operating Officer	Left May 2021	0	N/A	1	N/A	N/A	N/A	1
Jo Turl	Executive Director of Commissioning - Out of Hospital)		8	N/A	1	6	0	N/A	5

John Dowell	Chief Finance Officer		10	6	7	0	N/A	N/A	6
John Finn	Acting Director of in Hospital Commissioning		7	N/A	8	N/A	0	N/A	5
Simon Tapley	Interim Accountable Officer		8	N/A	1	N/A	N/A	0	1
Locality GPs									
David Greenwell	Clinical representative (southern)		10	N/A	0	N/A	N/A	N/A	N/A
John Womersley	Clinical representative (northern)		11	6	9	11	N/A	N/A	N/A
Shelagh McCormick	Clinical representative (western)		10	N/A	N/A	11	9	4	N/A
Simon Kerr	Clinical representative (eastern)		10	5	N/A	N/A	1	N/A	6

Secondary Care GP									
Nick Kennedy	Secondary care doctor		10	2	N/A	8	2	2	5
Clinical Leads									
Claire Hooper	Clinical Lead for Planned Care		N/A	N/A	N/A	N/A	N/A	N/A	4
Dafydd Jones	Clinical Lead for Urgent Care		N/A	N/A	N/A	N/A	N/A	N/A	5
External									
Ruth Harrell	Director of Public Health for Plymouth		4	N/A	N/A	0	N/A	N/A	N/A
Lincoln Sargent	Director of Public Health Torbay		9	N/A	N/A	N/A	N/A	N/A	N/A
Steve Brown	Director of Public Health for Devon		5	N/A	N/A	0	N/A	N/A	N/A

Open and closed Risks 2021/2022					
Risk Id	Risk description	Date risk opened	Risk Score	Date closed	Reason for closure
148	There is a risk that Devon Doctors is unable to deliver a safe and effective service to the population of Devon. This includes their 111 and Integrated Urgent Care Service (Out of Hours).	26/04/2021	Significant		
149	There is a risk that adults with Eating Disorders are not able to access the necessary physical health checks. There is no commissioned service either within Primary Care or within the Specialist Eating Disorder pathway, for patients who require frequent monitoring, and Primary Care is increasingly not able to support them.	05/05/2021	Significant		
150	There is a risk that the Mayflower group is unable deliver safe and effective services due to a lack of poor clinical oversight and governance processes putting patients at risk. There is currently limited assurance that patients have a fair, equitable and	07/05/2021	Significant		

	safe access to appropriate appointments.				
151	There is a risk that the activity relating to CHC assessments and reviews, and requests for joint funding is impacting upon the ability of both the provider CHC and CCG Complex Care teams to undertake their wider responsibilities around quality assurance and effectiveness.	13/07/2021	Significant		
152	There is a risk that when colleagues return to offices following the relaxation of government restrictions related to the Covid-19 pandemic, that there will be the potential for office outbreaks of Covid-19 or impact on staff through social interactions outside of the workplace.	08/03/2022	High		
153	There is a risk to patient safety and experience within commissioned acute trust services, due to long waiting times for elective care, including diagnostics, across Devon (adult and child).	19/10/2021	Significant		
154	There is a risk that commissioning Anti-viral prophylaxis through the PCN model could result in	26/10/2021	Significant	3 rd Feb 2022	This service has now been commissioned from Devon Docs (and will no longer be offered to GP practices).

	inconsistency and gaps in provision across the County if some PCNs choose not to participate.				
155	There is a risk that a lack of primary care data/data sharing prevents commissioners from properly understanding demand, capacity and effectively implementing a population health management (PHM) approach.	26/10/2021	High	8 th March 2022	There is a system risk (159) which covers the same area. It has been agreed that this system risk should be the one to continue.
156	There is a potential risk that there will be a delay in DRSS being able to identify 'red flags' within 'routine' referrals, due to a sizeable and growing backlog of referrals awaiting administrative and clinical review. Whilst not a specific service specification, DRSS has assumed this 'gatekeeper' role to provide referring clinicians with the opportunity to raise the referral status from 'routine' and expedite as 'urgent'.	05/11/2021	Medium		
157	There is a risk that combined historic workforce challenges, changing national and regional requirements including the requirements around continuity of carer, changes to thresholds for induction	24/11/2021	Significant		

	of labour, personalisation etc and the impact of the ongoing Covid-19 Pandemic will impact on safe delivery of maternity services and maternity services ability to implement national directives.				
158	There is a risk to the organisation caused by a tool called Log4j which is widely used within CCG and GP IT infrastructure.	05/01/2022	Medium	26 th May 2022	Updated following review of scans completed in environment and fixes released from software suppliers and implemented.
159	There is a risk that the start of the 2year system wide PHM implementation plan will be further delayed due to low numbers of Primary Care GP practices signing & returning information sharing agreements to enable data sharing.	07/01/2022	High		
160	There is a risk that the operational plan for 2022/23 is not deliverable within the resources allocated to the system and this jeopardises the wider system plan.	03/02/2022	Significant		
161	Two sub-contracted providers of Devon Special Allocations Scheme have handed back their contracts to main contractor Access Health Ltd. (Fremington Health Centre (North) and St Levan Surgery (West)).	08/03/2022	High		

162	There is a risk that PHB Holders do not know the tasks they need to complete when they employ PAs, including: *Ensuring the PAs are adequately trained, to include core skills training and Delegated Healthcare Tasks (DHTs) and *	05/04/2022	High		
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Financial statements

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**Statement of Comprehensive Net Expenditure for the year ended
31 March 2022**

	Note	2021-22 £'000	2020-21 £'000
Other operating income	2	(23,715)	(20,653)
Total operating income		(23,715)	(20,653)
Staff costs	4	29,953	28,993
Purchase of goods and services	5	2,551,369	2,208,683
Depreciation and impairment charges	5	717	864
Other Operating Expenditure	5	591	2,224
Total operating expenditure		2,582,630	2,240,764
Net Operating Expenditure		2,558,915	2,220,111
Other gains and losses	8	350	-
Net expenditure for the Year		2,559,265	2,220,111
Comprehensive Expenditure for the year		2,559,265	2,220,111

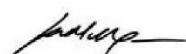
The notes on the following pages form part of this statement

**Statement of Financial Position as at
31 March 2022**

		2021-22	2020-21
	Note	£'000	£'000
Non-current assets:			
Property, plant and equipment	10	619	1,540
Intangible assets	11	244	1
Other financial assets	14	-	-
Total non-current assets		863	1,541
Current assets:			
Inventories	12	896	748
Trade and other receivables	13	8,095	18,520
Cash and cash equivalents	15	424	719
Total current assets		9,415	19,987
Total assets		10,278	21,528
Current liabilities			
Trade and other payables	16	(164,503)	(149,016)
Other financial liabilities	17	-	-
Borrowings	18	(1,780)	(9,305)
Provisions	19	-	-
Total current liabilities		(166,283)	(158,321)
Non-Current Assets plus/less Net Current Assets/Liabilities		(156,005)	(136,793)
Non-current liabilities			
Trade and other payables		-	-
Other financial liabilities	17	(72)	(85)
Provisions		-	-
Total non-current liabilities		(72)	(85)
Assets less Liabilities		(156,077)	(136,878)
Financed by Taxpayers' Equity			
General fund		(156,077)	(136,878)
Total taxpayers' equity:		(156,077)	(136,878)

The notes on the following pages form part of this statement

The financial statements on the following pages were approved by the Governing Body on 16 June 2022 and signed on its behalf by:



Jane Milligan
Accountable Officer

31 March 2022

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2021-22		
Balance at 01 April 2021	(136,878)	(136,878)
Transfer between reserves in respect of assets transferred from closed NHS bodies	-	-
Adjusted NHS CCG balance at 31 March 2022	(136,878)	(136,878)
Changes in NHS CCG taxpayers' equity for 2021-22		
Net expenditure for the financial year	(2,559,265)	(2,559,265)
Net Recognised NHS CCG Expenditure for the Financial year	(2,559,265)	(2,559,265)
Net funding	2,540,066	2,540,066
Balance at 31 March 2022	(156,077)	(156,077)
Changes in taxpayers' equity for 2020-21		
Balance at 01 April 2020	(119,880)	(119,880)
Opening transfers by absorption	-	-
Adjusted NHS CCG balance at 31 March 2021	(119,880)	(119,880)
Changes in NHS CCG taxpayers' equity for 2020-21		
Net expenditure for the financial year	(2,220,111)	(2,220,111)
Net Recognised NHS CCG Expenditure for the Financial Year	(2,220,111)	(2,220,111)
Net funding	2,203,113	2,203,113
Balance at 31 March 2021	(136,878)	(136,878)

The notes on the following pages form part of this statement

**Statement of Cash Flows for the year ended
31 March 2022**

	Note	2021-22 £'000	2020-21 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(2,559,278)	(2,220,114)
Depreciation and amortisation	5	717	864
Other Gains & Losses	8	350	-
(Increase)/decrease in inventories	12	(148)	(93)
(Increase)/decrease in trade & other receivables	13	10,425	(9,045)
Increase/(decrease) in trade & other payables	16	15,661	18,529
Increase/(decrease) in provisions	19	0	0
Net Cash Inflow (Outflow) from Operating Activities		(2,532,273)	(2,209,859)
Cash Flows from Investing Activities			
(Payments) for property, plant and equipment	10	(319)	(62)
(Payments) for intangible assets	11	(244)	0
Net Cash Inflow (Outflow) from Investing Activities		(563)	(62)
Net Cash Inflow (Outflow) before Financing		(2,532,836)	(2,209,921)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		2,540,066	2,203,113
Net Cash Inflow (Outflow) from Financing Activities		2,540,066	2,203,113
Net Increase (Decrease) in Cash & Cash Equivalents	15	7,230	(6,808)
Cash & Cash Equivalents at the Beginning of the Financial Year		(8,586)	(1,778)
Transfer from other public bodies under absorption		0	-
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		(1,356)	(8,586)

The notes on the following pages form part of this statement

Notes to the financial statements

1 Accounting Policies

NHS England has directed that the financial statements of CCGs shall meet the accounting requirements of the Group Accounting Manual (GAM) issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2021-22 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards (IFRS) to the extent that they are meaningful and appropriate to Clinical Commissioning Groups (CCGs), as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the CCG for the purpose of giving a true and fair view has been selected. The particular policies adopted by the CCG are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

Management is required to assess, at the time of preparing the financial statements, the entity's ability to continue as a going concern. The accounting concept of a going concern refers to the basis on which an organisation's assets and liabilities are recorded and included in the accounts. If an organisation is a going concern it is expected to operate for the foreseeable future, usually 12 months from the date the final accounts have been approved by the Governing Body (in this case 12 months from the end of June 2022). An organisation that was not a going concern would prepare its accounts on a different basis, reflecting their value on the winding up of the entity. Consequently, assets are more likely to be recorded at a much lower break-up value and medium and long-term liabilities would become short-term liabilities.

Indicators of an uncertain future would include the failure to achieve one or more statutory financial duties, for example, the breach of the resource limit, or operating with negative cash flows. In 2021/22 the CCG achieved a £5.275m surplus and operated within the annual cash drawdown requirement. To ensure that health services continue to meet the needs of the population and to support the achievement of national performance targets, the 2022/23 CCG plans indicate that it will be a very challenging year. The 2022/23 plan will have an impact on the cash flow of the CCG. However, overall cash is managed at an NHS England level. Therefore, if the total cash used by NHS England does not breach its cash limit, set by Treasury and the Department of Health, NHS England will have the flexibility to provide cash support to CCGs when needed.

The Health and Care Act was introduced into the House of Commons on 6 July 2021. The Bill will allow for the establishment of Integrated Care Boards (ICB) across England and will abolish clinical commissioning groups (CCG). ICBs will take on the commissioning functions of CCGs. Should the Bill be passed the CCG functions, assets and liabilities will therefore transfer to an ICB. It is expected that the commissioning functions of the CCG will be undertaken by the newly formed statutory body from 1 July 2022. The Department of Health and Social Care Group Accounting Manual 2021-22 states that for non-trading entities in the public sector, the anticipated continuation of the provision of service in the future, as evidenced by inclusion of financial provision of that service in published documents, is normally sufficient evidence of going concern. The 2021-22 Annual Report will discuss and review the CCGs future service plans and aims for their local populations.

With the above in mind the Governing Body of Devon CCG has prepared these financial statements on a going-concern basis. This is effectively in relation to its intention to continue its operations for the foreseeable future and the awareness of any circumstances affecting this in its preparation of these financial statements.

1.2 Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.3 Joint arrangements

Arrangements over which the CCG has joint control with one or more other entities are classified as joint arrangements. Joint control is the contractually agreed sharing of control of an arrangement. A joint arrangement is either a joint operation or a joint venture.

A joint operation exists where the parties that have joint control have rights to the assets and obligations for the liabilities relating to the arrangement.

Where the CCG is a joint operator it recognises its share of, assets, liabilities, income and expenses in its own accounts.

The CCG has entered into five arrangements, four of which has been assessed as joint operations.

The first of which is a joint operation under a Section 75 agreement with Plymouth City Council (PCC) to form the Plymouth Integrated Fund to manage Health and Social Care spending for the population of Plymouth. There are two elements to the integrated fund being 1) pooled funds (including the Plymouth Better Care Fund (BCF)) and 2) aligned funds where they cannot be managed within the pool but can be aligned for inclusion in the risk share arrangements. Under the section 75 agreement the CCG is the host to the pooled element of the fund however PCC remain lead commissioner for their element of spend within the pool. Under a joint operation each entity accounts for its share of the arrangement.

The second of which is a joint operation under a Section 75 agreement with Devon County Council (DCC) to form the Devon BCF. DCC are host to the fund and the CCG is lead commissioner to some of the funds elements. The net cost of the Devon BCF is reported within other programme costs.

Under a joint operation each entity accounts for its share of the arrangement.

Council.

The arrangement for Torbay is hosted by the CCG. The CCG accounts for its share of the income and expenditure arising from the activities of the arrangements, identified in accordance with the pooled budget agreements.

If the CCG is involved in a joint venture, the parties that have joint control have rights to the net assets of the arrangement. This must involve a separate vehicle and will need to account for their interest as an investment. Joint ventures are accounted for using the equity method.

Joint ventures that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

The CCG has entered into a joint venture with Plymouth City Council for the provision of IT services through the company DELT Shared Services (DELT). DELT commenced providing services on 1 September 2014. No IT assets transferred from the CCG to DELT. Existing IT assets remain on the CCG's fixed asset register with the exception of GPIT assets which remain on the NHS England's fixed asset register.

The CCG holds a shareholding interest in DELT in respect of 1 A ordinary Share with a nominal total value of £1 being 50% of the total shareholding and 30 B ordinary shares with a total nominal value of £30 being 30% of the total shareholding. This shareholding is held within the CCG's fixed asset register but due to the immaterial value is not visible in the annual accounts.

The CCG has considered the materiality of DELT as an entity and has concluded that the value falls below a materiality threshold and therefore group accounts have not been prepared.

1.4 Revenue

The CCG receives its main funding through a resource allocation from NHS England. This is drawn down and credited to the general fund.

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:

- As per paragraph 121 of the Standard the CCG will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less.
- The CCG is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.
- The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the CCG to reflect the aggregate effect of all contracts modified before the date of initial application.

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

Payment terms are standard reflecting cross government principles.

The majority of the income the CCG receives is pass-through funds from organisations, for example from NHS England, as well as refunds for drugs the CCG purchased during the year.

The value of the benefit received when the CCG accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

1.5 Employee Benefits

1.5.1 Short-term Employee Benefits

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.5.2 Retirement Benefit Costs

Past and present employees are covered by the provisions of the NHS Pensions Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as if they were a defined contribution scheme; the cost recognised in these accounts represents the contributions payable for the year. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the CCG commits itself to the retirement, regardless of the method of payment.

Some employees have joined the National Employment Savings Trust (NEST) pension scheme which is a defined contribution scheme and was set up by the government. The contributions the employee makes, along with the level of growth from the investments, will determine the size of the pension available on retirement.

1.6 Other Expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.7 Grants Payable

Where grant funding is not intended to be directly related to activity undertaken by a grant recipient in a specific period, the CCG recognises the expenditure in the period in which the grant is paid. All other grants are accounted for on an accruals basis.

1.8 Property, Plant & Equipment

1.8.1 Recognition

Property, plant and equipment is capitalised if:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to the CCG;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and,
- The item has a cost of at least £5,000; or,
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.8.2 Measurement

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use; and,
- Specialised buildings – depreciated replacement cost.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are re-valued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

1.8.3 Subsequent Expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.9 Intangible Assets

1.9.1 Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the CCG's business or which arise from contractual or other legal rights. They are recognised only:

- When it is probable that future economic benefits will flow to, or service potential be provided to, the CCG;
- Where the cost of the asset can be measured reliably; and,
- Where the cost is at least £5,000.

Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised but is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- The technical feasibility of completing the intangible asset so that it will be available for use;
- The intention to complete the intangible asset and use it;
- The ability to sell or use the intangible asset;
- How the intangible asset will generate probable future economic benefits or service potential;
- The availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and,
- The ability to measure reliably the expenditure attributable to the intangible asset during its development.

1.9.2 Measurement

Intangible assets acquired separately are initially recognised at cost. The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost or the value in use where the asset is income generating. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances. Revaluations and impairments are treated in the same manner as for property, plant and equipment.

1.9.3 Depreciation, Amortisation & Impairments

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the CCG expects to obtain economic benefits or service potential from the asset. This is specific to the CCG and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life.

At each reporting period end, the CCG checks whether there is any indication that any of its property, plant and equipment assets or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.10 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

1.10.1 The CCG as Lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the CCG's surplus/deficit.

Notes to the financial statements

- Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.
Contingent rentals are recognised as an expense in the period in which they are incurred.
Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.
- 1.11 **Inventories**
Inventories are valued at the lower of cost and net realisable value. The CCG's share of the inventory in the Better Care Fund with Devon County Council is disclosed in note 12.
- 1.12 **Cash & Cash Equivalents**
Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.
In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the CCG's cash management.
- 1.13 **Provisions**
Provisions are recognised when the CCG has a present legal or constructive obligation as a result of a past event, it is probable that the CCG will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:
All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:
• A nominal short-term rate of 0.47% (2020-21: minus 0.02%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
• A nominal medium-term rate of 0.70% (2020-21: 0.18%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.
• A nominal long-term rate of 0.95% (2020-21: 1.99%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.
• A nominal very long-term rate of 0.66% (2020-21: 1.99%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.
When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.
A restructuring provision is recognised when the CCG has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.
- 1.14 **Clinical Negligence Costs**
NHS Resolution operates a risk pooling scheme under which the CCG pays an annual contribution to NHS Resolution, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with CCG. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the CCG is disclosed in Note 19.
- 1.15 **Non-clinical Risk Pooling**
The CCG participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the CCG pays an annual contribution to the NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.
- 1.16 **Contingent liabilities and contingent assets**
A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the CCG, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.
or more uncertain future events not wholly within the control of the CCG. A contingent asset is disclosed where an inflow of economic benefits is probable.
Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.
- 1.17 **Financial Assets**
Financial assets are recognised when the CCG becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.
Financial assets are classified into the following categories:
• Financial assets at amortised cost;
• Financial assets at fair value through other comprehensive income and ;
• Financial assets at fair value through profit and loss.
The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.
- 1.17.1 **Financial Assets at Amortised cost**
Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.
- 1.17.2 **Financial assets at fair value through other comprehensive income**
Financial assets held at fair value through other comprehensive income are those held within a business model whose objective is achieved by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest.
- 1.17.3 **Financial assets at fair value through profit and loss**

Notes to the financial statements

Financial assets measured at fair value through profit and loss are those that are not otherwise measured at amortised cost or fair value through other comprehensive income. This includes derivatives and financial assets acquired principally for the purpose of selling in the short term. The CCG has no embedded derivatives that are required to be accounted for separately. The CCG's only financial assets are trade receivables and cash and cash equivalents which are disclosed in note 21.2. Trade receivables are recognised at the consideration agreed at the date of the transaction and the cash and cash equivalents are recognised at face value.

1.17.4 Impairment

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the CCG recognises a loss allowance representing the expected credit losses on the financial asset.

The CCG adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The CCG therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's length bodies and NHS bodies and the CCG does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1.18 Financial Liabilities

Financial liabilities are recognised on the statement of financial position when the CCG becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

1.18.1 Financial Guarantee Contract Liabilities

Financial guarantee contract liabilities are subsequently measured at the higher of:

- The premium received (or imputed) for entering into the guarantee less cumulative amortisation; and,
- The amount of the obligation under the contract, as determined in accordance with IAS 37: Provisions, Contingent Liabilities and Contingent Assets.

1.18.2 Financial Liabilities at Fair Value Through Profit and Loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the CCG's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability. The CCG has no embedded derivatives that are required to be accounted for separately.

1.18.3 Other Financial Liabilities

The CCG's other financial liabilities are trade payables and loans with external bodies. These are disclosed in note 21.3. Trade payables are recognised at the consideration agreed at the date of the transactions. Loans with external bodies is a technical overdraft with the bank due to the CCG meeting its obligation to pay general practitioners, at the start of the month, while ensuring the bank account balance is within 1.25% of the CCG's March's funding. Loans with external bodies is recognised as the full value of the BACs run processed.

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health and Social Care, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.19 Value Added Tax

Most of the activities of the CCG are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.20 Foreign Currencies

The CCG's functional currency and presentational currency is pounds sterling and amounts are presented in thousands of pounds unless expressly stated otherwise. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the CCG's surplus/deficit in the period in which they arise. No significant foreign currency transactions occurred during the year.

1.21 Third Party Assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the CCG has no beneficial interest in them.

1.22 Critical accounting judgements and key sources of estimation uncertainty

In the application of the CCG's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.22.1 Critical accounting judgements in applying accounting policies

The following are the judgements, apart from those involving estimations, that management has made in the process of applying the CCG's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

Apart from the accounting treatment of the better care fund budgets mentioned in 1.3 above and those involving estimations (see below), management has made no other critical accounting judgements in the process of applying the CCG's accounting policies that would have a significant effect on the amounts recognised in the financial statements:

1.22.2 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Notes to the financial statements

Estimation techniques are used to ensure that the correct levels of income and expenditure relating to current year are included through the inclusion of accruals. These are based on known commitments and local knowledge. Historically the difference between the estimated accruals and actual cost have not been material and it is expected to follow suit this year. The accruals will be carried forward into 2022/23 and matched against the actual costs incurred within the CCG.

For the main acute contracts the year end forecasts are based on the full year effect of the financial framework put in place in 2021/22.

Regarding prescribing costs, the CCG relies on the Business Services Authority's (BSA) forecasting methodology applied to primary care prescribing as well as local factors that fall outside of the national model. Due to the timing of published data the year end position includes an estimate for both February and March's prescribing costs.

Other estimates and judgements made in applying the CCG's accounting policies relate to the valuation of Property, Plant and Equipment and Intangibles. The nature of the assumptions and carrying value of the assets and liabilities are detailed in note 10 and 11 respectively.

1.23 Accounting Standards That Have Been Issued But Have Not Yet Been Adopted

The Department of Health and Social Care GAM does not require the following IFRS Standards and Interpretations to be applied in 2021-22. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2022/23, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

- IFRS 16 Leases – The Standard is effective 1 April 2022 as adapted and interpreted by the FReM.

IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. IFRS 16 specifies how an organisation will recognise, measure, present and disclose leases. The standard provides a single lessee accounting model, requiring lessees to recognise assets and liabilities for all leases unless the lease term is 12 months or less or the underlying asset has a low value. This would require the CCG to recognise the current operating leases for its headquarters as non-current assets, currently estimated at a value of £2.694m, with corresponding lease liabilities. This will result in a yearly depreciation and interest charge over the term of the lease, with an income statement expense which is higher than the straight-line rent expense typically recognised under the current standards, falling to a lower cost mid-way through the lease as the interest cost reduces. Under the current and future (IFRS 16) standard the overall cost of the transaction over the life of the lease is the same.

- IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021. Standard is not yet adopted by the FReM which is expected to be April 2023; early adoption is not therefore permitted. This standard will apply to companies that write insurance contracts and as such would have no effect on the CCG's financial position.

2 Other Operating Revenue

	2021-22 Total £'000	2020-21 Total £'000
Income from sale of goods and services (contracts)		
Education, training and research	-	-
Non-patient care services to other bodies	-	-
Other Contract income	-	-
Recoveries in respect of employee benefits	-	-
Total Income from sale of goods and services	-	-
Other operating income		
Non cash apprenticeship training grants revenue	58	30
Other non contract revenue	23,657	20,623
Total Other operating income	23,715	20,653
Total Operating Income	23,715	20,653

The main CCG funding is not included in this note. Revenue received from NHS England is drawn down directly into the bank account of the CCG and credited to the General Fund.

3 Disaggregation of Income - Income from sale of good and services (contracts)

The CCG receives income as part of the joint arrangements with its partner organisations. Income also includes reimbursements for cost of drugs and GP IT that the CCG purchased during the year.

4 Employee benefits and staff numbers

4.1.1 Employee benefits

	Total		2021-22
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	20,462	2,263	22,725
Social security costs	2,343	-	2,343
Employer Contributions to NHS Pension scheme	4,249	-	4,249
Other pension costs	5	-	5
Apprenticeship Levy	82	-	82
Termination benefits	-	-	-
Gross employee benefits expenditure	<u>27,141</u>	<u>2,263</u>	<u>29,404</u>
Less recoveries in respect of employee benefits (note 4.1.2)	-	-	-
Total - Net admin employee benefits including capitalised costs	<u>27,141</u>	<u>2,263</u>	<u>29,404</u>
Less: Employee costs capitalised	-	-	-
Net employee benefits excluding capitalised costs	<u>27,141</u>	<u>2,263</u>	<u>29,404</u>

	Total		*Restated 2020-21
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	21,284	1,157	22,441
Social security costs	2,249	-	2,249
Employer Contributions to NHS Pension scheme	4,024	-	4,024
Other pension costs	5	-	5
Apprenticeship Levy	92	-	92
Termination benefits	182	-	182
Gross employee benefits expenditure	<u>27,836</u>	<u>1,157</u>	<u>28,993</u>
Less recoveries in respect of employee benefits (note 4.1.2)	-	-	-
Total - Net admin employee benefits including capitalised costs	<u>27,836</u>	<u>1,157</u>	<u>28,993</u>
Less: Employee costs capitalised	-	-	-
Net employee benefits excluding capitalised costs	<u>27,836</u>	<u>1,157</u>	<u>28,993</u>

*Included in Salaries and Wages for Permanent Employees is £549k that was original disclosed within note 5 Operating Expenses of the 2020/21 accounts under category Supplies and Services – General. The adjustment was within Programme costs and had no effect on the running costs of the CCG.

4.2 Average number of people employed

	2021-22			2020-21		
	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number	Total Number
Total	439.08	38.52	477.60	438.40	37.73	476.13
Of the above: Number of whole time equivalent people engaged on capital projects	-	-	-	-	-	-

4.3 Staff Annual Leave Accrual Balances

	Total £000s	2021-22 Permanent Staff £000s	Temp/Agency £000s	Total £000s	2020-21 Permanent £000s	Temp/Agency £000s
	(524)	(524)	-	(754)	(754)	-

4.4 Exit packages agreed in the financial year

There were no agreed exit packages in 2021/22

	2021-22 Compulsory redundancies		2021-22 Other agreed departures		2021-22 Total	
	Number	£	Number	£	Number	£
Less than £10,000	-	-	-	-	-	-
£10,001 to £25,000	-	-	-	-	-	-
£25,001 to £50,000	-	-	-	-	-	-
£50,001 to £100,000	-	-	-	-	-	-
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
Total	-	-	-	-	-	-

	2020-21 Compulsory redundancies		2020-21 Other Agreed Departures		2020-21 Total	
	Number	£	Number	£	Number	£
Less than £10,000	3	8,402	1	1,744	4	10,146
£10,001 to £25,000	1	12,000	-	-	1	12,000
£25,001 to £50,000	-	-	-	-	-	-
£50,001 to £100,000	-	-	-	-	-	-
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	1	160,000	-	-	1	160,000
Over £200,001	-	-	-	-	-	-
Total	5	180,402	1	1,744	6	182,146

	2021-22 Departures where special payments have been made		2020-21 Departures where special payments have been made	
	Number	£	Number	£
Less than £10,000	-	-	-	-
£10,001 to £25,000	-	-	-	-
£25,001 to £50,000	-	-	-	-
£50,001 to £100,000	-	-	-	-
£100,001 to £150,000	-	-	-	-
£150,001 to £200,000	-	-	-	-
Over £200,001	-	-	-	-
Total	-	-	-	-

4.5 Analysis of Other Agreed Departures

	2021-22 Other agreed departures		2020-21 Other agreed departures	
	Number	£	Number	£
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	-	-	1	1,744
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval*	-	-	-	-
Total	-	-	1	1,744

* As a single exit package can be made up of several components each of which will be counted separately in this table, the total number will not necessarily match the total number in the table above, which will be the number of individuals.

These tables report the number and value of exit packages agreed in the financial year. The expense associated with these departures may have been recognised in part or in full in a previous period.

Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.

No non-contractual payments were made to individuals where the payment value was more than 12 months' of their annual salary.

The Remuneration Report includes the disclosure of exit payments payable to individuals named in that Report.

4.6 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

4.6.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2022, is based on valuation data as 31 March 2021, updated to 31 March 2022 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

4.6.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The 2016 funding valuation also tested the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

HMT published valuation directions dated 7 October 2021 (see Amending Directions 2021) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pensions website at <https://www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports>.

5 Operating expenses

	2021-22 Total £'000	*Restated 2020-21 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	477	648
Services from foundation trusts	914,088	790,415
Services from other NHS trusts	790,546	580,574
Purchase of healthcare from non-NHS bodies	362,847	347,352
Purchase of social care	44,413	53,439
Prescribing costs	208,957	214,505
GPMS/APMS and PCTMS	213,729	204,343
Supplies and services – clinical	651	443
Supplies and services – general	2,977	1,118
Consultancy services	1,646	2,455
Establishment	7,500	8,021
Transport	61	68
Premises	2,309	2,748
Audit fees	98	93
Other non statutory audit expenditure		
· Internal audit services	-	-
· Other services	12	12
Other professional fees	936	1,961
Legal fees	360	176
Education, training and conferences	253	282
Non cash apprenticeship training grants	58	30
Total Purchase of goods and services	2,551,918	2,208,683
Depreciation and impairment charges		
Depreciation	716	862
Amortisation	1	2
Total Depreciation and impairment charges	717	864
Other Operating Expenditure		
Chair and Non Executive Members	310	280
Grants to Other bodies	1,022	428
Clinical negligence	1	1
Expected credit loss on receivables	(895)	1,369
Other expenditure	153	146
Total Other Operating Expenditure	591	2,224
	2,553,226	2,211,771

In accordance with SI 2008 no.489, The Companies Regulations 2008, the contract the CCG has with the external auditors, Grant Thornton UK LLP, has a limitation on their liability set at £2m.

The external audit fee, paid to Grant Thornton UK LLP, is £73,246 plus VAT totalling £87,895 for 2021/22. There is also an additional payment in 2021/22 of £8,500 (£10,200 including VAT) for 2020/21's audit that wasn't accounted for in 2020/21's accounts. 2020/21 audit fee therefore totalled £100,200, including the £10,200.

Included in the accounts is £10,000 plus VAT, totalling £12,000 (2020-21 £12,000), for the 2021/22 Mental Health Investment Standard assurance work.

COVID-19 related costs totalling £31.5m is included in the 2021/22 expenditure (£69.5m 2020/21). The majority of which is in Purchase of healthcare from non-NHS bodies.

6.1 Better Payment Practice Code

Measure of compliance	2021-22 Number	2021-22 £'000	2020-21 Number	2020-21 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	46,423	662,684	37,328	612,593
Total Non-NHS Trade Invoices paid within target	46,088	640,451	37,070	590,878
Percentage of Non-NHS Trade invoices paid within target	99.28%	96.65%	99.31%	96.46%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	1,028	1,672,619	2,861	1,410,948
Total NHS Trade Invoices Paid within target	1,003	1,668,322	2,759	1,407,407
Percentage of NHS Trade Invoices paid within target	97.57%	99.74%	96.43%	99.75%

The better payment practice code requires the CCG to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

6.2 The Late Payment of Commercial Debts (Interest) Act 1998

	2021-22 £'000	2020-21 £'000
Amounts included in finance costs from claims made under this legislation	-	-
Compensation paid to cover debt recovery costs under this legislation	-	-
Total	-	-

7 Income Generation Activities

The CCG undertakes income generation activities with an aim of achieving profit, which is then used in commissioning healthcare services. None of these activities had a full cost which exceeded £1m or was otherwise material.

8 Other Gains & Losses

	2021-22 £'000	2021-22 £'000
(Gain) / Loss on disposal of property, plant and equipment assets other than by sale	350	-
(Gain) / Loss on disposal of intangible assets other than by sale	-	-
(Gain) / Loss on disposal of financial assets other than held for sale	-	-
(Gain) / Loss on disposal of assets held for sale	-	-
Total	350	-

On reviewing the tangible and intangible non current assets accounted for by the CCG and used by Livewell Southwest, it was determined that the assets are no longer in use and disposed of resulting in an in year expense of £342k. In addition, during the year the CCG moved out of Crown Yealm House resulting in an in year loss on disposal of £8k.

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9 Operating Leases

9.1 As lessee

The CCG occupies and commissions services in properties owned and managed by NHS Property Services Ltd, Devon County Council, Linsu Ltd, Colston Trustees Ltd and Plymouth County Council. The costs incurred are shown in the note below.
Other lease is for the car park at Pomona House.

9.1.1 Payments recognised as an Expense	Land £'000	Buildings £'000	Other £'000	2021-22 Total £'000	Land £'000	Buildings £'000	Other £'000	2020-21 Total £'000
Payments recognised as an expense								
Minimum lease payments	-	473	14	487	-	543	14	557
Contingent rents	-	-	-	-	-	-	-	-
Sub-lease payments	-	-	-	-	-	-	-	-
Total	-	473	14	487	-	543	14	557

The CCG has operating leases with terms of between 0 and 7 years. The building lease figure is related to a number of properties where the CCG does not have the option to purchase the buildings or lease below market rent at the expiry of the lease period.

From 1 April 2019 the CCG has delegated responsibility for primary care commissioning and has entered into certain financial arrangements involving the use of GP Premises. Under:

- IAS 17 Leases
- SIC 27 Evaluating the substance of transactions involving the legal form of a lease
- IFRIC 4 Determining whether an arrangement contains a lease

The CCG has determined that those operating leases must be recognised, but, as there is no defined term in the arrangements entered into, it is not possible to analyse the arrangements over financial years. The financial value included in the Operating Expenses for 2021/22 is £11,121m.

9.1.2 Future minimum lease payments	Land £'000	Buildings £'000	Other £'000	2021-22 Total £'000	Land £'000	Buildings £'000	Other £'000	2020-21 Total £'000
Payable:								
No later than one year	-	406	14	420	-	473	14	487
Between one and five years	-	1,571	32	1,603	-	1,719	45	1,764
After five years	-	557	-	557	-	1,005	-	1,005
Total	-	2,534	46	2,580	-	3,197	59	3,256

Future minimum lease payments of the property assumes that the leases will be terminated as per the current agreement terms.

10 Property, plant and equipment

	Buildings excluding dwellings £'000	Plant & machinery £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
2021-22					
Cost or valuation at 01 April 2021	208	1,861	9,031	674	11,774
Additions purchased	-	-	144	-	144
Additions donated	-	-	-	-	-
Additions government granted	-	-	-	-	-
Additions leased	-	-	-	-	-
Reclassifications	-	-	-	-	-
Reclassified as held for sale and reversals	-	-	-	-	-
Disposals other than by sale	(208)	(1,857)	(5,439)	(600)	(8,104)
Upward revaluation gains	-	-	-	-	-
Impairments charged	-	-	-	-	-
Reversal of impairments	-	-	-	-	-
Transfer (to)/from other public sector body	-	-	-	-	-
Cumulative depreciation adjustment following revaluation	-	-	-	-	-
Cost/Valuation at 31 March 2022	-	4	3,736	74	3,814
Depreciation 01 April 2021	107	1,595	7,975	557	10,234
Reclassifications	-	-	-	-	-
Reclassified as held for sale and reversals	-	-	-	-	-
Disposals other than by sale	(119)	(1,670)	(5,439)	(527)	(7,755)
Upward revaluation gains	-	-	-	-	-
Impairments charged	-	-	-	-	-
Reversal of impairments	-	-	-	-	-
Charged during the year	12	79	589	36	716
Transfer (to)/from other public sector body	-	-	-	-	-
Cumulative depreciation adjustment following revaluation	-	-	-	-	-
Depreciation at 31 March 2022	0	4	3,125	66	3,195
Net Book Value at 31 March 2022	(0)	(0)	611	8	619
Purchased	(0)	(0)	611	8	619
Donated	-	-	-	-	-
Government Granted	-	-	-	-	-
Total at 31 March 2022	(0)	(0)	611	8	619
Asset financing:					
Owned	(0)	(0)	611	8	619
Total at 31 March 2022	(0)	(0)	611	8	619

Revaluation Reserve Balance for Property, Plant & Equipment

	Buildings £'000	Plant & machinery £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Balance at 01 April 2021	-	-	-	-	-
Revaluation gains	-	-	-	-	-
Impairments	-	-	-	-	-
Release to general fund	-	-	-	-	-
Other movements	-	-	-	-	-
Balance at 31 March 2022	-	-	-	-	-

10 Property, plant and equipment cont'd

10.1 Cost or valuation of fully depreciated assets

The cost or valuation of fully depreciated assets still in use was as follows:

	2021-22	2020-21
	£'000	£'000
Plant & machinery	4	958
Information technology	2,408	5,513
Furniture & fittings	-	169
Total	2,412	6,640

10.2 Economic lives

	Minimum	Maximum
	Life (years)	Life (Years)
Dwellings	-	-
Plant & machinery	-	-
Transport equipment	-	-
Information technology	-	5
Furniture & fittings	1	3

11 Intangible non-current assets

	Computer Software: Purchased £'000	Development Expenditure (internally generated) £'000	Total £'000
2021-22			
Cost or valuation at 01 April 2021	322	67	389
Additions purchased	244	-	244
Disposals other than by sale	(67)	-	(67)
Upward revaluation gains	-	-	-
Cost / Valuation At 31 March 2022	499	67	566
Amortisation 01 April 2021	322	66	388
Disposals other than by sale	(67)	-	(67)
Charged during the year	-	1	1
Amortisation At 31 March 2022	255	67	322
Net Book Value at 31 March 2022	244	0	244
Purchased	244	-	244
Donated	-	-	-
Government Granted	-	-	-
Total at 31 March 2022	244	-	244

Revaluation Reserve Balance for intangible assets

	Computer Software: Purchased £'000	Development Expenditure (internally generated) £'000	Total £'000
Balance at 01 April 2021	-	-	-
Revaluation gains	-	-	-
Impairments	-	-	-
Release to general fund	-	-	-
Other movements	-	-	-
Balance at 31 March 2022	-	-	-

11 Intangible non-current assets cont'd

11.1 Cost or valuation of fully amortised assets

The cost or valuation of fully depreciated assets still in use was as follows:

	2021-22 £'000	2020-21 £'000
Computer software: purchased	254	322
Development expenditure (internally generated)	67	58
Total	321	380

11.2 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Computer software: purchased	-	5

12 Inventories

	Drugs	Consumables	Other	Total
	£'000	£'000	£'000	£'000
Balance at 01 April 2021	-	676	72	748
Additions	-	148	-	148
Inventories recognised as an expense in the period	-	-	-	-
Balance at 31 March 2022	-	824	72	896

Inventories relate to the CCG's share of inventories held within the Devon Better Care Fund managed by Devon County Council as host of the pooled fund.

13.1 Trade and other receivables

	Current 2021-22 £'000	Non-current 2021-22 £'000	Current 2020-21 £'000	Non-current 2020-21 £'000
NHS receivables: Revenue	2,986	-	12,284	-
NHS prepayments	-	-	-	-
NHS accrued income	5	-	145	-
Non-NHS and Other WGA receivables: Revenue	2,126	-	3,644	-
Non-NHS and Other WGA receivables: Capital	-	-	-	-
Non-NHS and Other WGA prepayments	1,758	-	2,403	-
Non-NHS and Other WGA accrued income	1,149	-	1,363	-
Expected credit loss allowance-receivables	(796)	-	(1,692)	-
VAT	866	-	366	-
Other receivables and accruals	1	-	7	-
Total Trade & other receivables	8,095	-	18,520	-
Total current and non current	8,095		18,520	

As at 31 March 2022 there were no non-current trade and other receivables (none as at 31 March 2021).

There are no prepaid pensions contributions as at 31 March 2022 (none as at 31 March 2021).

The great majority of trade is with NHS England. As NHS England is funded by Government to provide funding to CCG's to commission services, no credit scoring of them is considered necessary.

13.2 Receivables past their due date but not impaired

	2021-22 DHSC Group Bodies £'000	2021-22 Non DHSC Group Bodies £'000	2020-21 DHSC Group Bodies £'000	2020-21 Non DHSC Group Bodies £'000
By up to three months	518	1,809	614	1,014
By three to six months	-	-	249	18
By more than six months	28	10	72	743
Total	546	1,819	935	1,775

£1,333k of the amount above has subsequently been recovered post year end as at 20 April 2022.

The CCG did not hold any collateral against receivables outstanding at 31 March 2022.

Receivables past their due date are stated at the consideration agreed at the date of the transaction and the carrying amount and terms have not been renegotiated.

	Trade and other receivables - Non DHSC Group Bodies £'000	Other financial assets £'000	Total £'000
Balance at 01 April 2021	(1,692)	-	(1,692)
Lifetime expected credit loss on credit impaired financial assets	-	-	-
Lifetime expected credit losses on trade and other receivables-Stage 2	-	-	-
Lifetime expected credit losses on trade and other receivables-Stage 3	-	-	-
Amounts written off	-	-	-
Other changes	896	-	896
Total	(796)	-	(796)

Other changes include income received relating to brought forward credit loss.

14 Other financial assets

14.1 Non-Current: capital analysis

The CCG holds a shareholding interest in DELT in respect of 1 A ordinary Share with a nominal total value of £1 being 50% of the total shareholding and 30 B ordinary shares with a total nominal value of £30 being 30% of the total shareholding. Due to the immaterial value it is not visible in the annual accounts.

15 Cash and cash equivalents

	2021-22 £'000	*Restated 2020-21 £'000
Balance at 01 April 2021	(8,586)	(1,778)
Net change in year	7,230	(6,808)
Balance at 31 March 2022	(1,356)	(8,586)
Made up of:		
Cash with the Government Banking Service (GBS)	423	718
Cash in hand	1	1
Cash and cash equivalents as in statement of financial position	424	719
Bank overdraft: Government Banking Service	(1,780)	(9,305)
Bank overdraft: Commercial banks	-	-
Total bank overdrafts	(1,780)	(9,305)
Balance at 31 March 2022	(1,356)	(8,586)

Patients' money held by the clinical commissioning group, not included above - -

The requirement for the CCG to pay general practices at the start of the month has resulted in a technical overdraft for the CCG. The bank is in credit (Cash with the Government Banking Service) while the BACS payment is in progress (Bank overdraft: Government Banking Services). NHS England funds are deposited into the CCG account on the day the general practices payments leave the account.

*The comparators have been amended in line with the disclosure in 2021/22.

16 Trade and other payables	Current 2021-22 £'000	Non-current 2021-22 £'000	Current 2020-21 £'000	Non-current 2020-21 £'000
Interest payable	-	-	-	-
NHS payables: Revenue	6,449	-	4,330	-
NHS payables: Capital	-	-	-	-
NHS accruals	21,294	-	674	-
NHS deferred income	-	-	26	-
Non-NHS and Other WGA payables: Revenue	19,947	-	8,962	-
Non-NHS and Other WGA payables: Capital	-	-	174	-
Non-NHS and Other WGA accruals	71,558	-	78,845	-
Non-NHS and Other WGA deferred income	50	-	264	-
Non-NHS Contract Liabilities	-	-	-	-
Social security costs	341	-	307	-
VAT	-	-	-	-
Tax	297	-	318	-
Payments received on account	-	-	-	-
Other payables and accruals	44,567	-	55,116	-
Total Trade & Other Payables	164,503	-	149,016	-
Total current and non-current	164,503		149,016	

Other payables and accruals include those for Primary Care, Placements, Acute Care and Community Services that are not part of Whole Government Accounts (WGA).

17 Other financial liabilities	Current 2021-22 £'000	Non-current 2021-22 £'000	Current 2020-21 £'000	Non-current 2020-21 £'000
Amortised cost	-	72	-	85
Total	-	72	-	85
Total current and non-current	72		85	

Amortised cost is operating costs amortised on a straight line basis. The CCG had no other liabilities as at 31 March 2022.

	Current 2021-22 £'000	Non-current 2021-22 £'000	*Restated Current 2020-21 £'000	Non-current 2020-21 £'000
18 Borrowings				
Bank overdrafts:				
· Government banking service	1,780	-	9,305	-
· Commercial banks	-	-	-	-
Total overdrafts	1,780	-	9,305	-
Total Borrowings	1,780	-	9,305	-
Total current and non-current	1,780		9,305	

The requirement for the CCG to pay general practices at the start of the month has resulted in a technical overdraft for the CCG. The bank is in credit while the BACS payment is in progress. NHS England funds are deposited into the CCG account on the day the general practices payments leave the account.

*The comparators have been amended in line with the disclosure in 2021/22.

18.1 Repayment of principal falling due

	Department of Health 2021-22 £'000	Other 2021-22 £'000	Total 2021-22 £'000
Within one year	-	1,780	1,780
Between one and two years	-	-	-
Between two and five years	-	-	-
Between one and five years	-	-	-
After five years	-	-	-
Total	-	1,780	1,780

	Department of Health 2020-21 £'000	Other 2020-21 £'000	Total 2020-21 £'000
Within one year	-	9,305	9,305
Between one and two years	-	-	-
Between two and five years	-	-	-
Between one and five years	-	-	-
After five years	-	-	-
Total	-	9,305	9,305

19 Provisions

Under the Accounts direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before establishment of the CCG. However, the legal liability remains with the CCG. The total value of legacy NHS Continuing Healthcare accounted for by NHS England on behalf of this CCG at 31 March 2022 is £ nil (£287k 31 March 2021).

£ nil is included in the provisions of NHS Resolution as at 31 March 2022 (£3k 31 March 2021) in respect of liabilities to third parties.

20 Contingencies

There are no contingent liabilities or assets to report in 2021/22 (none in 2020/21). Under the Accounts direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before establishment of the CCG. However, the legal liability remains with the CCG. The total value of legacy NHS Continuing Healthcare contingent liability accounted for by NHS England on behalf of this CCG at 31 March 2022 is £ 96k (£20k 31 March 2021).

21 Financial instruments

Financial instruments are disclosed at fair value. Due to the short term nature of the transactions, fair value for cash is recognised at its sterling value; trade receivables, trade payables, other financial assets and liabilities are stated at the consideration agreed at the date of the transaction, hence the carrying value is considered to be a reasonable approximation to fair value.

21.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because CCG is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The CCG has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the CCG in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the CCG standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the CCG and internal auditors.

21.1.1 Currency risk

The CCG is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The CCG has no overseas operations. The CCG and therefore has low exposure to currency rate fluctuations.

21.1.2 Interest rate risk

The CCG borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The CCG therefore has low exposure to interest rate fluctuations.

21.1.3 Credit risk

Because the majority of the CCG and revenue comes parliamentary funding, CCG has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

21.1.4 Liquidity risk

Parliament. The CCG draws down cash to cover expenditure, as the need arises. The CCG is not, therefore, exposed to significant liquidity risks.

21.1.5 Financial Instruments

As the cash requirements of NHS England are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS England's expected purchase and usage requirements and NHS England is therefore exposed to little

21 Financial instruments cont'd**21.2 Financial assets**

	Financial Assets measured at amortised cost 2021-22 £'000	Equity Instruments designated at FVOCI 2021-22 £'000	Total 2021-22 £'000	Financial Assets measured at amortised cost 2020-21 £'000	Equity Instruments designated at FVOCI 2020-21 £'000	Total 2020-21 £'000
Trade and other receivables with NHSE bodies	2,504	-	2,504	1,941	-	1,941
Trade and other receivables with other DHSC group bodies	865	-	865	14,489	-	14,489
Trade and other receivables with external bodies	2,899	-	2,899	1,014	-	1,014
Cash and cash equivalents	424	-	424	719	-	719
Total at 31 March 2022/2021	6,692	-	6,692	18,163	-	18,163

21.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2021-22 £'000	Other 2021-22 £'000	Total 2021-22 £'000	Financial Liabilities measured at amortised cost 2020-21 £'000	Other 2020-21 £'000	Total 2020-21 £'000
Loans with external bodies	1,780	-	1,780	9,305	-	9,305
Trade and other payables with NHSE bodies	244	-	244	501	-	501
Trade and other payables with other DHSC group bodies	32,306	-	32,306	7,135	-	7,135
Trade and other payables with external bodies	131,265	-	131,265	140,465	-	140,465
Other financial liabilities	72	-	72	85	-	85
Total at 31 March 2022/2021	165,667	-	165,667	157,491	-	157,491

The requirement for the CCG to pay general practices at the start of the month has resulted in a technical overdraft for the CCG. The bank is in credit (Cash with the Government Banking Service) while the BACS payment is in progress (Bank overdraft: Government Banking Services). NHS England funds are deposited into the CCG account on the day the general practices payments leave the account.

21.4 Maturity of financial liabilities

	Payable to DHSC 2021-22 £'000	Payable to Other bodies 2021-22 £'000	Total 2021-22 £'000	Payable to DHSC 2020-21 £'000	Payable to Other bodies 2020-21 £'000	Total 2020-21 £'000
In one year or less	32,550	133,117	165,667	7,636	149,773	157,409
In more than one year but not more than two years	-	-	-	-	7	7
In more than two years but not more than five years	-	-	-	-	40	40
In more than five years	-	-	-	-	35	35
Total at 31 March 2022/2021	32,550	133,117	165,667	7,636	149,855	157,491

22 Operating segments

The CCG consider they have only one segment, commissioning of healthcare services.

	Gross expenditure £'000	Income £'000	Net expenditure £'000	Total assets £'000	Total liabilities £'000	Net assets £'000
Commissioning of Healthcare Services	2,582,980	(23,715)	2,559,265	10,278	(166,355)	(156,077)

Wherever possible the CCG manages resources and commissioning on a locality basis. Whilst this covers gross expenditure, which is reported using segmental analysis, this is not sufficient to necessitate a full reanalysis of the CCG's spend within these accounts.

23 Joint arrangements - interests in joint operations

CCGs should disclose information in relation to joint arrangements in line with the requirements in IFRS 12 - Disclosure of interests in other entities.

23.1 Interests in joint operations

Name of arrangement	Parties to the arrangement	Description of principal activities	Amounts recognised in Entities books ONLY				Amounts recognised in Entities books ONLY			
			2021-22		2020-21		2021-22		2020-21	
			Assets £'000	Liabilities £'000	Income £'000	Expenditure £'000	Assets £'000	Liabilities £'000	Income £'000	Expenditure £'000
Devon Better Care Fund	Devon County Council	Provision of integrated care	896	-	28,267	61,126	748	-	26,423	58,091
Plymouth Integrated Fund	Plymouth City Council	Provision of integrated care	-	-	12,657	185,578	-	-	12,657	180,027
Joint Community Equipment Store	Torbay Council	Provision of community equipment	-	-	-	754	-	-	-	747
Better Care Fund Torbay	Torbay Council	Provision of integrated care services	-	-	-	12,417	-	-	-	11,800

23.2 Interests in entities not accounted for under IFRS 10 or IFRS 11

Name of entity	Description of principal activities	Basis for treatment eg materiality
DEL T Shared Services Ltd	IT Services	Materiality

24 Related party transactions**2021/22**

During the year, apart from the following transactions none of the Department of Health Ministers, leadership or members of the key management staff, or parties related to any of them, has undertaken any material transactions with Devon CCG.

Details of related party transactions are as follows:

	2021-22	2021-22	2021-22	2021-22
	Payments to	Receipts	Amounts	Amounts
	Related Party	from	owed to	due from
	£'000	Related Party	Related Party	Related Party
	£'000	£'000	£'000	£'000
DELT SHARED SERVICES LTD	9,170	(407)	179	(407)
DEVON COUNTY COUNCIL	164,115	(2,246)	882	(166)
DEVON DOCTORS LTD	35,791	(206)	1,532	(32)
PLYMOUTH CITY COUNCIL	84,878	(13,729)	209	(1,718)
TORBAY COUNCIL	14,966	(463)	41	(39)

The CCG has responsibility for GP primary care commissioning and therefore management of the payments made to GP surgeries payable under the Primary Medical Services (PMS) and General Medical Services (GMS) contracts. As such some of the GP Governing Body members and senior management will be partners within GP practices that receive payments from the CCG for medical services rendered. These payments have not been disclosed as the medical contract, including the financial payments are predominantly agreed at a national level.

The majority of the GP members of the Governing Body and GP senior management, who are also GP partners at practices, will have a voting share of Devon Doctors Ltd. Devon Doctors Ltd is a social enterprise organisation that provide out-of-hours GP care.

The Department of Health and Social Care is regarded as a related party. During the year, the CCG has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. The most significant transactions for the CCG were with the following:

Devon Partnership NHS Trust
 NHS England
 NHS Property Services Ltd
 North Bristol NHS Trust
 Northern Devon Healthcare NHS Trust
 Royal Brompton & Harefield NHS Foundation Trust
 Royal Cornwall Hospitals NHS Trust
 Royal Devon and Exeter NHS Foundation Trust
 South Western Ambulance NHS Foundation Trust
 Taunton & Somerset NHS Foundation Trust
 Torbay and South Devon NHS Foundation Trust
 University College London Hospitals NHS Foundation Trust
 University Hospitals Bristol and Weston NHS Foundation Trust
 University Hospitals Plymouth NHS Trust

In addition, the CCG has had a number of material transactions with other Government Departments and other central and local Government bodies. The most significant of these transactions have been with Torbay Council, Devon County Council and Plymouth County Council, details of which are included above.

24 Related party transactions**2020/21**

During the year, apart from the following transactions none of the Department of Health Ministers, leadership or members of the key management staff, or parties related to any of them, has undertaken any material transactions with Devon CCG.

Details of related party transactions are as follows:

	2020-21 Payments to Related Party £'000	2020-21 Receipts from Related Party £'000	2020-21 Amounts owed to Related Party £'000	2020-21 Amounts due from Related Party £'000
Delt Shared Services Ltd	9,390	(135)	264	-
Devon County Council	125,774	(2,888)	19	(220)
Devon Doctors Ltd	34,236	(17)	100	(55)
Plymouth City Council	83,458	(15,421)	-	(3,325)
Torbay Council	4,258	(92)	-	(22)

The CCG has responsibility for GP primary care commissioning and therefore management of the payments made to GP surgeries payable under the Primary Medical Services (PMS) and General Medical Services (GMS) contracts. As such some of the GP Governing Body members and senior management will be partners within GP practices that receive payments from the CCG for medical services rendered. These payments have not been disclosed as the medical contract, including the financial payments are predominantly agreed at a national level.

The majority of the GP members of the Governing Body and GP senior management, who are also GP partners at practices, will have a voting share of Devon Doctors Ltd. Devon Doctors Ltd is a social enterprise organisation that provide out-of-hours GP care.

The Department of Health and Social Care is regarded as a related party. During the year, the CCG has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. The most significant transactions for the CCG were with the following:

Devon Partnership NHS Trust
NHS England
NHS Property Services Ltd
North Bristol NHS Trust
Northern Devon Healthcare NHS Trust
Royal Brompton & Harefield NHS Foundation Trust
Royal Cornwall Hospitals NHS Trust
Royal Devon and Exeter NHS Foundation Trust
South Western Ambulance NHS Foundation Trust
Taunton & Somerset NHS Foundation Trust
Torbay and South Devon NHS Foundation Trust
University College London Hospitals NHS Foundation Trust
University Hospitals Bristol and Weston NHS Foundation Trust
University Hospitals Plymouth NHS Trust

In addition, the CCG has had a number of material transactions with other Government Departments and other central and local Government bodies. The most significant of these transactions have been with Torbay Council, Devon County Council and Plymouth County Council, details of which are included above.

The CCG has made a provision of £508k for doubtful debts in relation to the above related parties.

25 Events after the end of the reporting period**25.1 Coronavirus (Covid-19)**

Although the "Living with Covid" plan has been introduced across the UK, ending the previous Covid restrictions, Covid has continued to put the NHS under immense pressure as individuals continue to be infected.

Covid-19 related treatment has resulted in a reduction in demand and supply in other services which consequently has increased waiting list sizes, for example for elective care. In addition, there is uncertainty of the long-term effect of Covid-19 on the country, however it is clear that the NHS has been and is a necessary and a vital part of the solution to keep the population healthy.

25.2 Establishment of Integrated Care Boards (ICBs)

The Health and Care Act received Royal Assent on 28 April 2022. The Act will allow for the establishment of Integrated Care Boards (ICB) across England and will abolish clinical commissioning groups (CCG). ICBs are due to take on the commissioning functions of CCGs from 1 July 2022. On this date the CCG's functions, assets and liabilities are due to transfer to NHS Devon ICB.

25.3 Financial Statements

The financial statements were approved by the Governing Body and authorised for issue on 16 June 2022.

The above mentioned post balance sheet events have no material effect on the 2021/22 financial statements of the CCG.

26 Financial performance targets

NHS Clinical Commissioning Group have a number of financial duties under the NHS Act 2006 (as amended).

NHS Clinical Commissioning Group performance against those duties was as follows:

	2021-22	2021-22	2020-21	2020-21	2021-22	2020-21
	Target	Performance	Target	Performance	Duty	Duty
	£'000	£'000	£'000	£'000	Achieved?	Achieved?
Expenditure not to exceed income	2,588,644	2,583,369	2,241,000	2,241,000	Y	Y
Capital resource use does not exceed the amount specified in Directions	389	389	236	236	Y	Y
Revenue resource use does not exceed the amount specified in Directions	2,564,540	2,559,265	2,220,111	2,220,111	Y	Y
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-	n/a	n/a
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-	n/a	n/a
Revenue administration resource use does not exceed the amount specified in Directions	23,720	21,337	24,111	22,696	Y	Y

The CCG met the requirement for spend not to exceed the capital and overall revenue resources received during the year. The CCG's overall expenditure was less than the income and revenue resource received during the year resulting in a surplus of £5.275m (balanced position in 2020/21).

	2021-22	2020-21
	£000	£000
Programme Expenditure	2,561,445	2,217,928
Administration Expenditure	21,535	22,836
Total Expenditure	2,582,980	2,240,764
Programme Income	(23,517)	(20,513)
Administration Income	(198)	(140)
Total Income	(23,715)	(20,653)
	2,559,265	2,220,111
Revenue Resource Limit (RRL)	2,564,540	2,220,111
Surplus/(Deficit)	5,275	0
Surplus/(Deficit) % of Revenue Resource Limit	0.21%	0.00%

Independent auditors report

Independent auditor's report to the members of the Governing Body of NHS Devon Clinical Commissioning Group

Report on the Audit of the Financial Statements

Opinion on financial statements

We have audited the financial statements of NHS Devon Clinical Commissioning Group (the 'CCG') for the year ended 31 March 2022, which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 15 of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the CCG as at 31 March 2022 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2020) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the CCG in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Emphasis of matter – Demise of the organisation

In forming our opinion on the financial statements, which is not modified, we draw attention to note 25.2 to the financial statements, which indicates that, under the Health and Care Act 2022 we are expecting the commissioning functions of NHS Devon CCG to transfer to NHS Devon Integrated Care Board on 1 July 2022.

Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Accountable Officer's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the CCG's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the CCG to cease to continue as a going concern.

In our evaluation of the Accountable Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group accounting manual 2021 to 2022 that the CCG's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services currently provided by the CCG. In doing so we have

had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2020) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the CCG and the CCG's disclosures over the going concern period.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the CCG's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

In auditing the financial statements, we have concluded that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

The responsibilities of the Accountable Officer with respect to going concern are described in the 'Responsibilities of the Accountable Officer and Those Charged with Governance for the financial statements' section of this report.

Other information

The Accountable Officer is responsible for the other information. The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office in April 2020 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not comply with the guidance issued by NHS England or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion, based on the work undertaken in the course of the audit:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 15 of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the CCG, the other information published together with the financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Opinion on regularity of income and expenditure required by the Code of Audit Practice

In our opinion, in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions in the financial statements conform to the authorities which govern them.

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or
- we refer a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we make a written recommendation to the CCG under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters.

Responsibilities of the Accountable Officer and Those Charged with Governance for the financial statements

As explained more fully in the Statement of Accountable Officer's responsibilities, the Accountable Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accountable Officer is responsible for assessing the CCG's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the CCG without the transfer of its services to another public sector entity.

The Accountable Officer is responsible for ensuring the regularity of expenditure and income in the financial statements.

The Audit Committee is Those Charged with Governance. Those Charged with Governance are responsible for overseeing the CCG's financial reporting process.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

We are also responsible for giving an opinion on the regularity of expenditure and income in the financial statements in accordance with the Code of Audit Practice.

Explanation as to what extent the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. Owing to the inherent limitations of an audit, there is an unavoidable risk that material misstatements in the financial statements may not be detected, even though the audit is properly planned and performed in accordance with the ISAs (UK).

The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the CCG and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022).
- We enquired of management and the Audit Committee, concerning the CCG's policies and procedures relating to:
 - the identification, evaluation and compliance with laws and regulations;
 - the detection and response to the risks of fraud; and
 - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management, and the Audit Committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.
- We assessed the susceptibility of the CCG's financial statements to material misstatement, including how fraud might occur, evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls and fraud risks in relation to income recognition and expenditure. We determined that the principal risks were in relation to:
 - material year end journals and manual journals posted during the year with high risk characteristics
 - potential management bias in determining estimates for year end prescribing accrual.
- Our audit procedures involved:
 - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
 - journal entry testing, with a focus on the material year end transactions and manual journals posted during the year with high risk characteristics;
 - challenging assumptions and judgements made by management in its significant accounting estimates in respect of prescribing accruals;
 - assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.
- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.
- The team communications in respect of potential non-compliance with relevant laws and regulations, including the potential for fraud in revenue and expenditure recognition, and the significant accounting estimates related to prescribing accruals.

- Our assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's:
 - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
 - knowledge of the health sector and economy in which the CCG operates
 - understanding of the legal and regulatory requirements specific to the CCG including:
 - the provisions of the applicable legislation
 - NHS England's rules and related guidance
 - the applicable statutory provisions.
- In assessing the potential risks of material misstatement, we obtained an understanding of:
 - The CCG's operations, including the nature of its operating revenue and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement.
 - The CCG's control environment, including the policies and procedures implemented by the CCG to ensure compliance with the requirements of the financial reporting framework.

Report on other legal and regulatory requirements – the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception – the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2022.

Our work on the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources is not yet complete. The outcome of our work will be reported in our commentary on the CCG's arrangements in our Auditor's Annual Report. If we identify any significant weaknesses in these arrangements, they will be reported by exception in a further auditor's report. We are satisfied that this work does not have a material effect on our opinion on the financial statements for the year ended 31 March 2022.

Responsibilities of the Accountable Officer

As explained in the Annual Governance Statement, the Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the CCG's resources.

Auditor's responsibilities for the review of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We undertake our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in December 2021. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the CCG plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the CCG ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the CCG uses information about its costs and performance to improve the way it manages and delivers its services.

We document our understanding of the arrangements the CCG has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we consider whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate for the NHS Devon CCG for the year ended 31 March 2022 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice until we have completed our work on the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources.

Use of our report

This report is made solely to the members of the Governing Body of the CCG, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the members of the Governing Body of the CCG those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the CCG and the members of the Governing Body of the CCG as a body, for our audit work, for this report, or for the opinions we have formed.

Alex Walling

Alex Walling, Key Audit Partner

for and on behalf of Grant Thornton UK LLP, Local Auditor

Bristol

20 June 2022